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HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

DOCUMENTS DEPT.

OCT 29 2003

January 27, 2003
4:30 - 7:30 PM

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AGENDA

- 7/03
- | | | |
|-------|--|---------|
| I. | Call to Order | 4:30 PM |
| II. | Roll Call | 4:32 PM |
| III. | Review and Approval of Agenda | 4:35 PM |
| IV. | Review and Approval of Minutes, <u>November 25, 2002</u> | 4:40 PM |
| V. | General Announcements | 4:45 PM |
| VI. | Public Comment | 4:50 PM |
| VII. | Presentation -- Proposed changes to State budget & impact on ADAP and other services -- Dana van Gorder (SF AIDS Foundation) & Anne Donnelly (Project Inform) | 5:00 PM |
| | <ul style="list-style-type: none"> Dana van Gorder and Anne Donnelly will review proposed changes to the state budget and the impact they may have on California's AIDS Drug Assistance Program (ADAP) and other HIV programs. | |
| | <i>Public Comment on this item</i> | |
| VIII. | Presentation -- Proposed changes to overall health services -- Colleen Johnson (SF DPH) | 5:15 PM |
| | <ul style="list-style-type: none"> Colleen Johnson will report on the potential impact from proposed State budget changes to overall health services, especially Medi-Cal, including potential impact on SFDPH budget and services. | |
| | <i>Public Comment on this item</i> | |
| IX. | Presentation -- SFDPH, HIV Health Services Quarterly Report - Michelle Long Dixon, SFDPH, HIV Health Services | 5:30 PM |

- Michelle Long Dixon will provide the Council with a short presentation updating the Council on the current fiscal year's contracting and certification progress.

Public Comment on this item

X. Presentation -- Legislative Update -- Michelle Long Dixon, SFDPH, HIV Health Services 5:45 PM

- Michelle Long Dixon will provide the Council with a short presentation updating the Council on the federal legislative situation regarding the Fiscal Year 2003-04 appropriations process.

Public Comment on this item

Dinner Break 6:00 PM

XI. Presentation -- Report Back from CAEAR Coalition Foundation Training -- Charles Siron & Randy Allgaier, PLWH Advisory Committee Co-chairs 6:15 PM

- Charles Siron and Randy Allgaier will provide a brief presentation on their training from the CAEAR Coalition Foundation at the December 4 - 7 meeting in Tampa, Florida.

Public Comment on this item

XII. Committee Report -- Co-Chair Report/Steering Committee-- Change of Next Meeting Date -- VOTE 6:35 PM

- Steering Committee moves to change the February HIV Health Services Planning Council meeting date from February 24, 2003 to February 13, 2003. The proposed meeting on February 13, 2003 will be a joint meeting with the San Francisco HIV Prevention Planning Council.

Public Comment on this item

XIII. Committee Report -- Housing Committee -- HOPWA Loan Committee Recommendation -- VOTE 6:45 PM

- The Housing Committee moves to implement the Council's decision made on 11/25/02, to adopt a policy that at least one of the two, preferably both, Council seats on the HOPWA Loan Committee should be reserved for someone living with HIV/AIDS and that both seats should preferably be held by Council members who do not have a conflict of interest related to the HOPWA program. Both seats will not be filled at the same time.

- The Housing Committee moves to open nominations to the full Council to fill one of the two seats on the HOPWA Loan Committee.
- At their last meeting, the Housing Committee unanimously endorsed the nomination of Brad Hume to assume one of the two HOPWA Loan Committee positions because of his knowledge and experience as a consumer.

Public Comment on this item

XIV. Committee Report -- Membership Committee -- 6:55 PM
Recommendation of Re-appointment of John Conley -- VOTE

- The Membership Committee forwards their unanimous recommendation to re-appoint John Conley to the HIV Health Services Planning Council for a term of two years commencing February 1, 2003.

Public Comment on this item

XV. Committee Report -- PLWH Advisory Committee 7:05 PM

Public Comment on this item

XVI. Committee Report -- Implementation & Evaluation Committee 7:10 PM

Public Comment on this item

XVII. Committee Report -- Grantee Assessment Task Force 7:15 PM

Public Comment on this item

XVIII. New Business 7:20 PM

Public Comment on this item

XVII. Adjourn 7:30 PM

*Note: Agenda items are subject to change, postponement, or removal.
Meeting agendas are considered to be in DRAFT form until reviewed and approved by Council attendees.*

HIV Health Services Planning Council

973 Market Street, 6th Floor, San Francisco, CA 94103

San Francisco Department of Public Health, AIDS Office

25 Van Ness Avenue, 5th floor, San Francisco, CA 94102

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Upcoming HIV Health Services Planning Council Meetings:

February 2003

Steering Committee	Mon. 3rd	5:00-6:30	25 Van Ness Ave., Rm. 330A
Grantee Assessment Task Force	Tues. 4th	3:00-5:00	25 Van Ness Ave., Rm. 330B
Membership Committee	Mon. 10th	4:30-6:30	25 Van Ness Ave., Rm. 330A
Implementation & Evaluation Committee	Tues. 11th	3:00-5:00	25 Van Ness Ave., Rm. 330B
Housing Committee	Wed. 12th	3:00-5:00	25 Van Ness Ave., Rm. 330B
People Living with HIV Advisory Committee	Wed. 12th	5:30-7:30	25 Van Ness Ave., Rm. 330A
PROPOSED HIV Health Services Planning Council	Thurs. 13th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201
Steering Committee	Tues. 18th	5:00-6:30	25 Van Ness Ave., Rm. 330B
HIV Health Services Planning Council	Mon. 24th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201

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[Membership Committee](#) | [Planning Committee](#) | [Steering Committee](#)

San Francisco

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

January 27, 2003

4:30 - 7:30 PM

MINUTES

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I. Call to Order 4:30 PM

II. Roll Call 4:32 PM

A quorum was achieved (See Attachment A).

III. Review and Approval of Agenda 4:35 PM

The Agenda was approved with no objection.

IV. Review and Approval of Minutes, November 25, 2002 4:40 PM

Sam Kaplan made a change to the minutes. The minutes were moved and seconded.

V. General Announcements 4:45 PM

Norman Tanner announced he received his appointment letter from the Mayor.

Catherine Geanuracos has been offered a position with UCSF doing HIV Prevention work. She will be able to stay with the Council until the end of her term. She is hoping to find a young person to sit on the Council from Larkin Street Youth Center.

Eric Whitney announced that a blue Satisfaction Survey was sent out with the packet, and he would like people to return those to support staff by the end of the meeting. He invited interested parties to join him for a conference call with HRSA tomorrow to discuss the effects of partial awards.

On February 24, 2003, Council members are invited to attend the Planning Council Volunteer Appreciation and Member Recognition event to honor former and current members.

Tricia Turner requested Council members complete and submit their Annual Statement of Economic Interest. She is available to assist anyone with

questions.

Randy Allgaier announced that the PLWH Advisory Committee will be holding a training for Council members who are living with HIV from 12pm-5pm on February 20, 2003 at the LGBT Center in room Q11.

Margot Antonetty announced that the Health Commission will be meeting on February 5, 2003 at the Board of Supervisor's room for Dr. Katz to present the proposed DPH budget for FY '03-'04.

Patrick Monette-Shaw provided the following announcement: I have asked the U.S. Department of Health and Human Services' Inspector General to audit this Council during its upcoming audit of the SF EMA. After all, you are integral to providing fiscal oversight to the SF EMA.

VI. Public Comment

4:50 PM

Walter Miller Jr., from the Oakland HIV Planning Council, invited all to attend their Council meeting on February 5, 2003 from 1pm-3pm. Call (510) 465-7333 for further details.

Howell Sims, the new Executive Director of Shanti, introduced himself to the Council..

Bill Hirsh, Director of ALRP and member of HAPN, explained that HAPN acts to advocate for clients and to improve coordination among contractors. They do not speak on behalf of specific agencies.

Patrick Monette-Shaw provided written public comment as follows:

On 11/3 I filed a disclosure request regarding allocation of \$1.68 million in rollover funds, not knowing Michelle Long Dixon had already mailed the interest inquiry letters to ASO's on 10/21. DPH failed on 11/19 to provide the full list of ASO's who received the letters; it has dragged its feet since, not providing them, just as DPH fails to provide this Council timely documents. DPH did supply copies of the carry-forward notices mailed 12/24; having analyzed the notices in a database I created, shown in this report. \$878,557 of the \$1.68 million may not have been awarded to contractors. Is it intentionally being reserved to award your co-workers at ASO's fatter COLA raises? In this second report, \$6.4 million is not accounted for; is this amount in MOU's? Just as this EMA is about to be audited by Washington, aren't you interested in where this money is squirreled away?

VII. Presentation -- Proposed changes to overall health services -- Colleen Johnson (SF DPH)

5:00 PM

Colleen Johnson, Assistant Director of Policy and Planning of SF DPH, monitors State legislative and budget action. As many already know, the California budget faces a large deficit. The governor has planned to supplement the gap, but in order to do so, many cuts must be implemented.

One of the major shifts includes a plan to transfer program responsibilities to counties. The governor has also proposed to reinstate the Vehicular Licensing Fee or VLF, which was originally developed to backfill local government deficits. This will significantly affect San Francisco.

The realignment 2 proposal would institute 3 new taxes: a cigarette tax, income tax on higher end incomes, and a 1 cent sales tax. Several programs including the Healthy Communities program, In Home Supportive Services, and Court Security would shift down to the county's responsibility as well.

The changes to the MediCal program are noteworthy. The governor is hoping to change eligibility for Medical. If the proposal is passed, 5900 in SF will fall off of MediCal. The income eligibility would change from 100% poverty level to 75% poverty level. Currently, each year, people have to provide proof of eligibility for MediCal. The governor hopes to change this requirement to quarterly proofs. This would make it harder for people to supply the proof, thus maintain their benefit. Other changes to MediCal include a plan to retract the expansion of the aged and disabled program. Included in the proposal is the elimination of 18 optional MediCal services, including adult dental, medical supplies, podiatry, acupuncture, chiropractic, psychology, independent rehabilitation centers, occupational therapy, non-emergency medical transportation, optician/optical lab services, hospice, durable medical equipment, optometry, hearing aids, prosthetics, speech/audiology, orthotics, physical therapy.

VIII. Presentation -- Proposed changes to State budget & impact on ADAP and other services -- Dana van Gorder (SF AIDS Foundation) & Anne Donnelly (Project Inform)

5:15 PM

Dana van Gorder suggested that the Republicans in Congress will fight to avoid any tax increases. This will make revenue increases very unlikely. ADAP has needed about a \$20 million per year increase to function due to increases in costs and eligible recipients. There is a proposal to reduce Prevention programs by about \$1.5 million. About \$2.3 million would be reduced from University research for HIV. The governor also proposed increasing ADAP about \$9 million, but much of that would be drawn from co-payments. Individuals 200% and below of the federal poverty level (FPL) would not be required to provide a co-payment. Individuals between 201%-300% of the FPL would be required to provide a \$30.00 co-payment per prescription. Individuals between 301%-400% of the FPL would be required to provide a \$45.00 co-payment per prescription. Individuals at 401% of the FPL and income below \$50,000 would be required to provide a \$50.00 co-payment per prescription.

Anne Donnelly explained that the implementing co-pays would translate into a stealth cut, because if you cannot afford the drugs, there are serious consequences to one's health. Any changes to MediCal will not be considered by the legislature in the midyear. The other changes will be going to the governor's desk this week.

Randy Allgaier asked if the advocacy community has looked at what would be acceptable co-pays. Dana van Gorder replied that one proposal suggested that co-pays be implemented starting at 100% FPL. Capping the number of prescriptions per month that require a co-payment was another proposal.

Sam Kaplan suggested that a major impact will be found with the MediCal elimination of supplemental services. Larry Cruz asked how much of the cut would be revenue enhancement. The presenters responded that 60% would be cuts, 24% would be increases, and 16% loans.

Anne Donnelly stated that the Federal government has recommended a stimulus package to all the states for medical purposes. Dana van Gorder stated that it is the first year that the Federal government has not proposed an increase to ADAP. This makes the state reductions even harder. Almost all pharmaceutical companies supplying HIV/AIDS drugs have agreed to provide a 2-year price freeze.

John Connelly stated that in San Mateo, the Advisory community has discussed worst case scenarios for ADAP co-pay increases, and supplementing those gaps with Title I funds. He suggested this may need to be addressed by this Council at some point. Jeff Byers reported that other EMAs have also discussed this possibility and reiterated how this could impact geographic differences. If people would like to discuss this further, contact Kathy Russell at the Office of AIDS for more information.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:

I have an absolutely dead serious idea on how to backfill ADAP. The preserve ADAP coverage to SF residents, why has the San Francisco AIDS Foundation's \$8 million net assets portfolio dropped to \$3.6 million? Can the \$4.4 million which has disappeared from SFAF's net assets be used to help backfill ADAP to help SFAF's clients or you CARE clients in San Francisco maintain their coverage for AIDS medications under ADAP? In the same SFAF audited financial statement, Cash and Cash Equivalents have soared to \$2.3 million. Can't SFAF use its new hefty cash and cash equivalents to help rescue ADAP here in SF?

**IX. Presentation -- SFDPH, HIV Health Services Quarterly Report - 5:30 PM
- Michelle Long Dixon, SFDPH, HIV Health Services**

Michelle Long Dixon distributed the December quarterly report (See Attachment B) and the solicitation for unobligated contracts. All of the CARE Contracts are open for certification, because they are being modified to include the Unfunds awards. Catherine Geanuraeos asked for an update on predictions for unexpended funds by the end of the year. All of the providers were asked if they could spend the money before the end of the fiscal year, so Michelle Long Dixon anticipates that most providers will be able to spend the money allocated. The AIDS Office staff is working on speeding up the certification process.

The AIDS Office is making progress on completing the Standards of Care, and thanked those Council members who have participated. Planning Council members will be distributed Standards of Care when they are complete. Rani Marx of the REGGIE staff, is on family leave, so her staff have been disbursed to HHS and the Prevention Sections of the AIDS Office.

The Minority Health Grant has been renewed at \$650,000. HRSA has notified HHS that a partial award will be granted for 4 months and will be holding a conference call tomorrow to discuss. John Conley suggested that a large cut would be significant later in the year, if a flat funding partial award is granted for the beginning of the fiscal year.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:

On August 26, 2002, this Council voted on the categories of services ranking based on a budget allocation document supplied by Michelle Long Dixon's department, outlining allocations by service category. I obtained an update to that budget on 9/4. On 9/23 I presented you an analysis of the 9/4 massive shifts in allocations; I now present you this analysis: As you can see from the last column, if SF receives a deep cut of \$15 million for next FY next month as Jimmy Lloyce anticipates, categories 6 through 30 will be eliminated entirely, based on your 9/23 scenario-setting vote; also, \$754,202 will be taken from category 5, Residential Programs and Subsidies. In addition, between 9/4 and 11/24, DPH shifted an additional \$589,369 from an unknown combination of categories into the Integrated Service Category, which I did not update here. Require DPH provide an update to the allocations before cutting services!

X. Presentation -- Legislative Update -- Michelle Long Dixon, SFDPH, HIV Health Services

5:45 PM

Michelle Long Dixon announced that Congress is currently working on an increase to CARE of about \$6 million, but that would translate into a cut of 2.9% of all programs. The House has not yet developed their version of the budget.

Susan Shea asked about the implications of a partial award and the possibility of cutting programs even before an award is final. She suggested the Council discuss how high up the prioritization sub-category list to cut. Michelle Long Dixon reported that cuts could be implemented at the beginning of the fiscal year, when partial awards are granted, but the decision of how high up the list cuts remains to be decided by the Council. Susan Shea suggested members of I & E Committee attend Steering Committee to discuss this further.

Public Comment on this item

There was no public comment on this agenda item.

Dinner Break

6:00 PM

XI. Presentation -- Report Back from CAEAR Coalition Foundation Training -- Charles Siron & Randy Allgaier, PLWH Advisory Committee Co-chairs

6:15 PM

Randy Allgaier and Charles Siron, co-chairs of the PLWH Advisory Committee, provided a presentation on the training they attended from the CAEAR Coalition Foundation in Tampa, Florida (See Attachment C). Issues discussed were: Planning Council support, membership recruitment and retention, the need for orientation and training, PLWH involvement with Council work, relationships with other EMAs. Randy Allgaier mentioned that it is especially necessary for the PLWH Advisory Committee to experience continuous attendance from PLWH/A to take a strong position on any matter.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:

I researched the Tom Sheridan's election campaign contributions during CARE Act Reauthorization 2000. Before this Council takes a seat on the CAEAR Coalition, you should make sure Tom Sheridan is not longer affiliated with the CAEAR Coalition, and that the Sheridan Group does not have a contract with the CAEAR Coalition, (as Randy Allgaier asserts) Tom Sheridan is not much different in kind than Dan Palotta. This Council should ask SFAF if it has stopped paying the Sheridan Group a \$95,000 annual contract, and whether SFAF has severed its ties with Tom Sheridan. Don't damage your credibility joining CAEAR if Sheridan is in any way still in followed with the CAEAR Coalition. As for creating a new award to honor Council members as heroes, we already have too many awards programs with lavish dinner parties to distribute them. Soon we'll have more awardees than we have people infected with HIV.

Bill Hirsh was under the impression that the CAEAR Coalition training

would include more information on how the Council can provide advocacy to increase or maintain CARE funding.

Walter Miller, Jr. explained that the Oakland EMA is working on developing "alternates" to make sure that PLWH are involved in all Council's decision making. He stated that all the PLWH on the Council should join the PLWH Advisory Committee because a strong voice from PLWH is essential to the Council process.

**XII. Committee Report -- Co-Chair Report/Steering Committee--
Change of Next Meeting Date -- VOTE**

6:35 PM

Brad Hume raised a proposal to move the February Council meeting to February 13, 2003. The reason for the change would be to accommodate a joint meeting with the HIV Prevention Planning Council. The Prevention Council's meeting would begin at 3:00pm, and the Planning Council would join them at 4:30pm for a presentation on the Vaccine trials. After the presentation, the Planning Council will begin to handle their regular business. The volunteer appreciation event would be held February 24, 2003, from 5:30-7:30 in the Mayor's Conference Room.

Public Comment on this item

Patrick Monette-Shaw asked the Steering Committee to refrain from hold this retreat soiree, and he assumes the event has been changed to a "training" to exclude participation from the public.

Outcome: The motion unanimously carried.

**XIII. Committee Report -- Housing Committee -- HOPWA Loan
Committee Recommendation -- VOTE**

6:45 PM

The Housing Committee met on January 8, 2003 and began reviewing how Title I money is spent on housing. The February meeting has been moved to February 12, 2003 because the DPII budget presentation at the Health Commission is being held on February 5, 2003.

The committee also decided to implement the HOPWA loan committee decision made at the last Council meeting; open nominations to the whole Council; and to endorse and forward the nomination of Brad Hume.

Norman Tanner nominated Tracy Neil. Elizabeth Colomello reviewed the responsibilities of the HOPWA Loan Committee members. There are times of the year that the work load is light, but some of the year requires an intense amount of work. Tracy Neil did not accept the nomination. George Simmons announced that the Ambassador Hotel is ready to open with 110 clean, safe units. Margot Antonetty reported that the Camelot and the Star are now open.

Public Comment on this item

There was no public comment on this agenda item.

Outcome: The motion unanimously carried to appoint Brad Hume to this position.

**XIV. Committee Report -- Membership Committee --
Recommendation of Re-appointment of John Conley -- VOTE**

6:55 PM

The Membership Committee forwarded their unanimous recommendation to re-appoint John Conley to the HIV Health Services Planning Council for a term of two years commencing February 1, 2003.

Kevin Johnson welcomed the Council members who are here. There will be four interviews of candidates at the next meeting. He asked for people to notify him in advance if they anticipate being absent. The committee is working on Policies and Procedures for membership issues. Steering Committee is also working on Policies and Procedures for committee process that would include expectations from HRSA.

Public Comment on this item:

Walter Miller, Jr. stated that if there is not a quorum at your committees, work is much harder to complete.

Anita Booker asked about more information about committees.

Outcome: The motion carried unanimously.

XV. Committee Report -- PLWH Advisory Committee

7:05 PM

Randy Allgaier reported that the PLWH Advisory Committee is busy working on Needs Assessment activities.

The committee will be holding a training on February 20, 2003 at the LGBT Center in room Q11, from 12pm-5pm, facilitated by Chris Sandoval of the Multicultural AIDS Resource Center of California.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:

During last week's Steering Committee meeting, CO-Chair Brad Hume specifically stated that he thought it was a good time to have a retreat of some sort to honor the HIV-positive members of the Council, as a way of thanking them for their hard work on the Council. I objected, saying that I didn't think it was appropriate to divert CARE Act funds to fund a social event for any Council members. I asked about the budget for this event,

and its agenda, but was told they were both "in development." A week later, this social event has had a name change and is now being billed as a training event. Based on my written testimony before the Steering Committee last week, you seem hell bent on changing the name of this event to keep the public from knowing it was conceived as a soiree.

Walter Miller, Jr. asked if public could attend. Randy Allgaier hopes for the group to rejuvenate their own energy before extending a training to community members.

XVI. Committee Report -- Implementation & Evaluation Committee 7:10 PM

Sam Kaplan reported that the committee had a successful discussion about Prioritization at their December meeting. The committee is hoping to gather feedback from the AIDS Office to improve future decisions and evaluations.

At their January meeting, the group discussed a proposed unfunds calendar developed by Susan Shea. At their next meeting, the group will discuss the purpose of the committee.

Public Comment on this item

Patrick Monette-Shaw provided public written comment as follows:

A reasonable person assumes the Implementation and Evaluation Committee would be keenly interested knowing how Michelle Long Dixon's DPH department is implementing guidance this Council is mandated by Congress to issue DPH, and whether DPH follows your instructions. To that end, I have asked elsewhere tonight why this Council has not required DPH provide you with an update to the budget allocations for each category of services. As you can see in an additional database report I generated from the award notices, Integrated Service Programs were awarded an additional \$589,369 over and above the amount DPH said was budgeted for such programs on 9/4. How and when - - between 9/4 and 12/24 when the award notices were mailed - did DPH reallocate ISP's additional funds without discussing them before this full Council? Did the I&E Committee give DPH this permission, without the public being able to comment on it beforehand?

XVII. Committee Report -- Grantee Assessment Task Force 7:15 PM

Randy Allgaier invited the group to the Grantee Assessment Task Force meeting tomorrow from 3pm-5pm. The group is working with Pat Dunn to develop the template for future activities and a MOU for Grantee Assessment purposes.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:

The December 16, 2002 Steering Committee minutes indicate the last Grantee Assessment report was completed two years ago, in 2000. Other minutes of various Council subcommittees speculate the loss of \$2.2 million from the current FY CARE Act award to SF last February may have been a direct result of failing to complete and submit grantee assessments to Washington. The current assessment of the Grantee - the San Francisco Department of Public Health - still appears incomplete. It is too late to submit one to Washington in hopes of minimizing further cuts next month for the FY beginning on March 1. What is the delay in completing this grantee assessment? Are you not getting cooperation from DPH? Are they not supplying you with information in a timely manner? As overseers of CARE funds to the SF EMA, this Council has an ethical responsibility to expedite completion of this assessment.

XVIII. New Business**7:20 PM**

Brad Hume explained that new business allows Council members to suggest future agenda items for the next Council meeting. The Sunshine Ordinance does not allow for discussion of items that are not already on the agenda.

Sam Kaplan suggested the Council receive a future training on how to use data effectively. Randy Allgaier suggested a training on how to understand current legislative updates. Donald Frazier suggested Council staff provide the group with a copy of the Three Year Plan, accompanied with a presentation.

Public Comment on this item:

Patrick Monette-Shaw announced that Jim Illig has requested a future agenda item that would address a deep-cut/worst case scenario. Susan Shea responded that the Council will handle this responsibility in their prioritization duties.

XIV. Adjourn**7:30 PM**

Meeting minutes are considered to be in DRAFT form until reviewed and approved by Council attendees.

Home | Community Outreach & Advocacy Committee | Infrastructure & Policy Committee | Evaluation Committee
Membership Committee | Planning Committee | Steering Committee

Combined Meeting of
HIV Prevention Planning Council &
HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

DOCUMENTS DEPT.

February 13, 2003
4:30 PM - 7:30 PM

OCT 29 2003

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AGENDA

- I. Dinner/Break with HIV Prevention Planning Council 4:15 PM
- II. Introduction to Collaborative Meeting with HIV Prevention Planning Council 4:30 PM
- III. Vaccine Trials: Overview, New Information, and Discussion -- 5:00 PM
Jen Sarche, Edd Lee
 - Jen Sarche, Community Educator of the SF DPH HIV Research Section and Edd Lee, Director of Education and Outreach of the AIDS Vaccine Advocacy Coalition will provide a presentation on the HIV Vaccine Research pipeline.
- Public Comment on this Agenda Item*
- IV. HIV Prevention Planning Council Closure & Evaluation 5:50 PM
- V. Break 6:00 PM
- VI. HIV Health Services Planning Council Roll Call 6:05 PM
- VII. Review and Approval of Agenda 6:07 PM
- VIII. Review and Approval of Minutes, January 27, 2003 6:09 PM
- IX. General Announcements 6:11 PM
- X. Public Comment 6:15 PM

XI. Committee Report -- Co-Chair Report/Steering Committee -- Planning Council Support -- VOTE 6:20 PM

- The Steering Committee is forwarding a motion to the full Council for the FY2003-04 Planning Council support budget of \$341,600. This amount is an increase of \$39,113 above the existing FY2002-03 budget of \$302,487, and \$91,600 above the "hold harmless" amount of \$250,000.

The Steering Committee makes the motion to increase the Planning Council Support budget to \$341,600, and proposes to facilitate this increase in the following manner:

Utilize the reduction scenario approved during **September 23, 2002** meeting; once the reduction scenario has been satisfied, utilize a proportional reduction scenario within the remaining Service Sub-categories to accommodate the increased revenue needed for the Planning Council Support budget increase.

Public Comment on this item

XII. Committee Report -- Housing Committee 6:55 PM

Public Comment on this item

XIII. Committee Report -- Membership Committee -- Recommendation of Appointment of Candidates -- VOTE 7:00 PM

- The Membership Committee will forward their recommendation to appoint nominees to the HIV Health Services Planning Council for a term of two years commencing March 1, 2003.

Public Comment on this item

XIV. Committee Report -- PLWH Advisory Committee 7:10 PM

Public Comment on this item

XV. Committee Report -- Implementation & Evaluation Committee 7:15 PM

Public Comment on this item

XVI. Committee Report -- Grantee Assessment Task Force 7:20 PM

Public Comment on this item

XVII. Next Agenda**7:25 PM***Public Comment on this item***XVIII. Adjourn****7:30 PM***Note: Agenda items are subject to change, postponement, or removal.**Meeting agendas are considered to be in DRAFT form until reviewed and approved by Council attendees.***HIV Health Services Planning Council****973 Market Street, 6th Floor, San Francisco, CA 94103**

San Francisco Department of Public Health, AIDS Office**25 Van Ness Avenue, 5th floor, San Francisco, CA 94102**

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Upcoming HIV Health Services Planning Council Meetings:**February 2003****Grantee Assessment Task Force****Tues. 18th****3:00-5:00****25 Van Ness Ave., 5th Fl.**

			Conf. Rm.
Steering Committee	Tues. 18th	5:00-6:30	25 Van Ness Ave., Rm. 330B
HIV Health Services Planning Council Volunteer Appreciation & Member Recognition Event	Mon. 24th	5:30-7:30	City Hall, Mayor's Conf. Rm. 201

March 2003

Grantee Assessment Task Force	Tues. 4th	3:00-5:00	25 Van Ness Ave., Rm. 330B
Housing Committee	Wed. 5th	3:00-5:00	25 Van Ness Ave., Rm. 330A
Membership Committee	Mon. 10th	4:30-6:30	25 Van Ness Ave., Rm. 330A
Implementation & Evaluation Committee	Tues. 11th	3:00-5:00	25 Van Ness Ave., Rm. 330B
People Living with HIV Advisory Committee	Wed. 12th	5:30-7:30	25 Van Ness Ave., Rm. 330A
Steering Committee	Mon. 17th	5:00-6:30	25 Van Ness Ave., Rm. 330A
HIV Health Services Planning Council	Mon. 24th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201

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~~San Francisco~~

Combined Meeting of HIV Prevention Planning Council & HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

February 13, 2003
4:30 - 7:30 PM

MINUTES

I. Introductions to Collaborative Meeting with HIV Prevention Planning Council

The Council members introduced themselves.

II. Vaccine Trials: Overview, New Information, and Discussion -- Jen Sarche, Edd Lee

Jen Sarche and Edd Lee from the Vaccine Trials distributed the presentation handout (See Attachment A). Many people are skeptical about the process, so a Community Advisory Board meets monthly to discuss the project. The San Francisco trials are part of a global network of testing. All of the trials provided by SF DPH are preventative, and UCSF handles therapeutic vaccine trials.

Edd Lee reported that this Spring, Vaccine trial results will be released. He anticipates that the media will be reporting on this, and people will assume that the epidemic is over. He added it is unlikely that the results will show the vaccine to be either highly effective or highly ineffective, as the trials would have been altered if it were found to be either. With results proving to be partially effective, behavioral change will be impacted. A control group was measured to compare risk reduction here in the U.S. A partially effective Vaccine could help curb infection rates, but that would affect people's needle safety and sex risk behaviors, which would actually make the HIV rate rise. Community planners should be concerned with the effects of a partially effective vaccine. Also, the government could withhold funding if they think the vaccine is fully effective.

Question & Answers

Q. Kevin Johnson asked about therapeutic vaccine currently being studied at UCSF.

A. Jen Sarche responded explaining that this vaccine is in very early stages of testing.

Q. Lyn Fischer asked about the implications to Rapid Testing, wondering if the vaccine will

cause false negatives.

A. Jeff Byers responded that the Rapid Test detects the presence of HIV antibodies that will also be present in people who have taken the vaccine. Such people will need to have the full HIV test, which is based on identifying the HIV's DNA.

Q. Steve Gibson stated that he is concerned about resultant behavior change among people at risk. He also expressed concerns that 30% efficacy is too low.

A. Jen Sarche responded stating that mathematically 30% efficacy has been determined to be sufficient to stabilize the epidemic, particularly in many countries currently highly impacted.

Edd Lee also explained that the FDA will not license a product below 30% efficacy.

Q. Steve Gibson reiterated that 30% seems low and asked if the AIDS Vaccine Advocacy Coalition supports that policy.

A. Edd Lee replied that 30% is significant, and asked if it were available, who wouldn't want to take it. Jen Sarche questioned if the Councils would actually want to advise CDC that 30% efficacy was too low. Would that have any effect? What would be the consequences?

Perhaps planning for the eventuality of it is a better use of limited resources.

Q. Tracy Neil asked what AIDSvax actually does.

A. Jen Sarche explained that it is a synthetic viral material that triggers an immune response. She noted that the material is similar enough to the exterior of the HIV virus to allow the immune system to be prepared to respond to HIV.

Q. Tracy Neil followed up regarding side effects.

A. In response, Jen Sarche stated that the side effects are relatively small and include some flu-like symptoms and soreness at the location of the injection. Q. Tracy Neil then asked why the tests were conducted in the venues outlined: North America, Netherlands and Puerto Rico.

A. Edd Lee stated that the places of test were chosen because VaxGen was able to conduct the tests there.

Q. Janetta Johnson asked if research shows significant changes in behavior after the use of the vaccine. She also questioned if there is likely to be changes similar to what was seen after the introduction of HIV medications.

A. Jen Sarche stated that the preliminary results indicate that the risky behavior and seroconversion declines among MSM, at least in the short term after taking the vaccine. She noted this is similar to results immediately after beginning HAART. She also recommended people check the Web Site (www.sfaidsresearch.org) for more detailed information.

A. In response to a question, Edd Lee stated that information on efficacy by race or gender is not yet available.

Q. Marcel Miranda asked if the mathematical model shows that 30% efficacy, or greater, is sufficient to have a significant impact, have the modelmakers figured out how much the vaccine will cost.

A. In response, Edd Lee stated that the development costs of any vaccine runs in the tens of millions, if approved VaxGen will build a manufacturing facility in Korea, and that it has not been determined how it might be distributed on poor countries. He added that there may be some sort of guaranteed purchase from wealthy countries, which would affect the cost. He also noted that it has not been determined if health insurance in the US will cover the vaccine. In all, and in lieu of a release date being four or more years away, no cost estimate is currently available.

Q. Hank Wilson stated that he was offended by research that is not fully reported. He added that over the years there have been various research studies of vaccines whose results have never been published, particularly about seroconversion. He asserted that if there is information, it should be published.

A. In response, Jen Sarche stated that the CAB process is open to the public. She added that

research guidelines are being prepared and will be published. Edd Lee also responded stating that the National Institutes of Health (NIH) publish Phase I & II data. He added that this information is generally in scientific journals and doesn't always make it into the mainstream media. He also noted that private companies are not required to publish the results of all of their research.

Q. Mary Lawrence Hicks asked what the issues are regarding Rapid Testing.

A. Edd Lee responded that there would be a lot of false positives. Jen Sarche added that the Rapid Test looks for antibody response, the other test can tell the difference. She also noted that if the vaccine is ever widely available, the use of Rapid Testing would change. Barbara Adler noted that positive preliminary test results requiring additional testing could add to service organizations' workload.

Q. Andre Robertson asked if the AIDSVax vaccine has application of sparking an immune response after contact.

A. Edd Lee stated that the vaccine creates an antibody response before contact with HIV.

Q. Andre Robertson followed up by asking if there is any positive effect from after contact use of the vaccine.

A. Edd Lee cautioned that the vaccine must not be seen as a 'CureAll.' He stated that part of the challenge for AIDS Service Organizations would be to educate people as to the vaccine's limitations.

Q. Andre Robertson asked if the vaccine could be taken every two months.

A. Edd Lee responded that such would not increase the efficacy since the first use would create the desired antibody response.

Q. Lyn Fischer stated that PEP has been 83% effective among healthcare workers, and asked if this has been looked at in conjunction with the vaccine. A. Jen Sarche stated that it has not as yet been looked at. She noted that PEP would slow down the testing process. Edd added that this is not part of VaxGen's protocol. Edd Lee distributed copies of a report regarding AIDSVax, a copy of which is included for absent Members. He also stated that people could find more information at www.avac.org.

III. HIV Prevention Planning Council Closure & Evaluation

Israel Nieves-Rivera asked for feedback on the desirability of future collaborative meetings, and topics that would be useful. A collaborative meeting regarding Prevention for Positives was suggested, as the final year of the project has just ended. Steve Gibson suggested discussion regarding what happens after completion of research projects. Lyn Fisher suggested exploring early care. It was recommended discussing prevention and primary care. Margot Antonetty suggested the Councils meet collaboratively at least once a year. Laura Thomas stated that members of both Councils have expressed interest in discussing the needs of the transgender community. Catherine Geanuracos suggested the Councils share certain needs assessments - both the requirements and results. Janetta Johnson stated her support for both exploration of the transgender community as well as collaboration on needs assessments.

IV. HIV Health Services Planning Council Rollcall

A quorum was achieved (See Attachment B).

V. Review and Approval of Agenda

The Agenda was approved with no objection.

VI. Review and Approval of Minutes, *January 27, 2003*

Jeff Byers made a correction to the minutes. The minutes were moved for approval and seconded.

VII. General Announcements

Donald Frazier announced that the Community Action Committee will be held sometime in March. Support staff will be sending out an announcement with the details.

Laura Thomas reported that Congress will be voting tomorrow on their Omnibus Budget bill which includes funding for the Ryan White CARE Act programs for the current fiscal year. The increase for Title I is \$3.36 million, and \$2 million of those dollars are earmarked for the Minority AIDS Initiative. ADAP will receive an \$80 million dollar increase. The formula award is based on an estimate of living AIDS cases. The MAI money is distributed based on a formula, which is based on the percent of people of color living with HIV in all of the EMAs. The supplemental amount is awarded on a competitive basis, based on how well the EMA does on the grant application. Catherine Geanuracos stated that the ranking is based on the proportional amount of living AIDS cases in all of the EMAs.

VIII. Public Comment

Naomi Prochovnich, of Tenderloin Care Continuum and the Executive Committee of the HIV/AIDS Provider Network, spoke regarding the Steering Committee proposal. She stated that HAPN is in favor of trainings and other Council activities, but many providers expressed great concern with taking money away from services to supplement the Council support budget. She reported that the group suggested looking at creative solutions so that more money is not taken away from providers who are also faced with administrative funding challenges.

IX. Committee Report -- Co-Chair Report/Steering Committee-- Planning Council Support-- **VOTE**

Motion Content:

The Steering Committee is forwarding a motion to the full Council for the FY2003-04 Planning Council support budget of \$341,600. This amount is an increase of \$39,113 above the existing FY2002-03 budget of \$302,487, and \$91,600 above the "hold harmless" amount of \$250,000.

The Steering Committee makes the motion to increase the Planning Council Support budget to \$341,600, and proposes to facilitate this increase in the following manner:

Utilize the reduction scenario approved during September 23, 2002 meeting; once the reduction scenario has been satisfied, utilize a proportional reduction scenario within the remaining Service Sub-categories to accommodate the increased revenue

needed for the Planning Council Support budget increase.

Discussion on Motion:

Brad Hume reviewed the discussion that occurred at Steering Committee. He stated that the motion was created to provide training, and assessment activities for the Council on a regular basis. In the past, many of these projects have been paid for by Rollover dollars, which may not be available in the future. At Steering Committee, concerns were expressed regarding taking money away from services to bolster the Council's administrative budget.

The current funding for Planning Council support is \$250,000. At the August 2002 prioritization, this amount was held harmless. After rollover dollars were allocated, another \$52,000 was added to account for Needs Assessment, Grantee Assessment and other activities. A document was distributed, created by Eric Whitney, that outlines the Council support line items (See Attachment C). The first column represents the amount the Contract is currently funded at (\$250,000). The second column represents this last fiscal year's funding, including the Carry Forward funding that were applied later in the year. The other two columns represent two proposals: the first being if funding was increased to \$341,600, and the second being if funding was increased to \$434,000. The percentile mark (%) represents the line item would receive adequate funding, a plus sign (+) represents minimal activity may occur, and the asterisk (*) represents significant doubt that activity would occur with the proposed funding amount.

Brad Hume reminded the group that once a motion is on the floor, it belongs to the entire group. There are no friendly amendments. If someone raises an amendment, then the group will discuss it, vote if necessary, then take it back to the original motion if the amendment fails. He added that this is a difficult situation because the support staff are in the room, and people should be mindful of that. Catherine Geanuracos anticipates that moving to a new contractor will be a positive change.

Jeff Byers spoke for the motion, but is concerned that the money would affect the prioritization process that occurred in August of 2002. Catherine Geanuracos replied that the after the reduction scenario is implemented, the money will be taken proportionately from the remaining sub-categories. Randy Allgaier spoke for the motion even after experiencing mixed feelings from attending the HAPN meeting. He stated that the Council needs constant sources of evaluation and training, and the group should not count on Unfunds in the future. Charlene Pugh spoke in favor of the motion because it is more cost effective to hire a new position instead of constantly hiring consultants. Lara Saltee spoke in favor of the motion because the Council must be trained to make decisions about providers which will eventually trickle down to consumers. She added that further reductions from HRSA make the situation more dire, and meeting their expectations could result in an increased award in the future. Mary Lawrence Hicks asked what types of training are needed that the staff cannot provide now. Catherine Geanuracos replied that HRSA has charged the group with recruiting unaffiliated consumers, who must be trained. Advocacy work requires training leaders. Mary Lawrence Hicks requested that the training money be used efficaciously. Susan Shea spoke in favor of the motion because the support contract has never had sufficient infrastructure. As a past co-chair, she would have continued in that leadership position if the level of support that is in place now was in place then. Susan Shea offered an amendment to use the reduction scenario, then take the increase proportionally from sub-categories 12 through the

bottom of the list to stay with the spirit of prioritization. Norman Tanner seconded.

In response to this amendment, Charlene Pugh spoke against the amendment. The amendment would significantly affect the lower level categories, possibly eliminating those that remain after the reduction scenario is implemented. Randy Allgaier spoke against the amendment because if the Council allows the bottom tier to handle the costs, the Council would not be sensitive to the cuts already in place. Jeff Byers spoke against the amendment. Ken Pearce spoke against the amendment. Susan Shea withdrew her amendment.

Catherine Geanuracos spoke against the motion, because she is concerned that the conditions at the current contractor have compromised what the Council support can provide. She anticipates that the Council support can operate successfully with a functional contractor. Charles Siron spoke for the motion after thinking about this issue critically. He hopes that the Council would value training for consumers. George Simmons spoke against the motion because he believes this is a breach of the protocols of prioritization, because the Council already agreed on their priorities. If this had been presented in September, he would support it, but the timing is difficult. Benjamin Reid spoke for the motion because you must invest in a program to see it grow.

John Conley agreed that this would revise prioritization, but he believes that consumer representatives need support and training for growth. Brad Hume spoke against the motion after thinking about this, even though he believes training and evaluation are so important. His concern about the contractor was addressed by Catherine Geanuracos. He also feels like he does not have the information he needs to make this decision in good conscious. He added that if a provider asked for a 30% increase, they would be faced with great scrutiny from the Council.

Jeff Byers raised concern that the Steering Committee co-chairs are speaking against the motion. Brad Hume made an amendment to the motion, that would change the amount from \$341,000 to the current fiscal year's amount (including the Rollover) of \$302,000. Susan Shea stated that the SF EMA spends close to the lowest percentage on their Planning Council support. She added that it would not make a difference to get a new contractor. No contractor is paid enough to make that significant enough of a change. Lara Sallee spoke against the amendment because she never received a training, and she believes this is for the providers' protection in future funding reductions. Kevin Johnson called the question. Brad Hume withdrew the amendment.

Outcome: The original motion carried.

X. Committee Report -- Housing Committee -- Update

At their last meeting the Housing Committee began the process of reviewing how Title I dollars are spent on housing.

XI. Committee Report -- Membership Committee -- Recommendation of Appointment -- VOTE

The Membership Committee forwarded their recommendation to appoint Darnell Durio and Phillip Gaston to the HIV Health Services Planning Council for a term of two years

commencing March 1, 2003.

Kevin Johnson reported that Sam Kaplan will not continue as the MediCal representative and Council support staff are in the process of finding a replacement for that mandated seat.

Outcome: The motion carried.

XII. Committee Report -- PLWH Advisory Committee

Randy Allgaier reported that the PLWH Advisory Committee spent much of their meeting speaking about Steering Committee's motion. At the next meeting, LaFrance and Associates will be presenting their recent Needs Assessment findings. Also, the Advisory Committee will be holding a training retreat for HIV-positive Council members on Feb. 20, 2003 from 12pm-5pm at the LGBT Center, Rm. Q11.

XIII. Committee Report -- Implementation & Evaluation Committee

Catherine Geanuracos reported that at the last I & E Committee, the group reviewed the roles and responsibilities of the committee.

XIV. Committee Report -- Grantee Assessment Task Force

Randy Allgaier reported that the group will be reviewing the updated Grantee Assessment standards at their next meeting, and will be finalizing the document by the end of the month.

XV. New Business

Susan Shea requested a prioritization presentation be provided in the upcoming month.

XVI. Adjourn

7:30
PM

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HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

DOCUMENTS DEPT.

March 24, 2003
4:30 PM - 7:30 PM

MAR 20 2003

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DRAFT AGENDA

- | | | |
|-------|---|---------|
| I. | Call to Order | 4:30 PM |
| II. | Roll Call | 4:32 PM |
| III. | Review and Approval of Agenda | 4:34 PM |
| IV. | Review and Approval of Minutes, <u>February 13, 2003</u> | 4:36 PM |
| V. | General Announcements | 4:40 PM |
| VI. | Public Comment | 4:45 PM |
| VII. | Overview of Ryan White Care Act Legislation and HRSA requirements -- Laura Thomas, SF DPH HIV Health Services | 5:00 PM |
| | Laura Thomas will provide a brief overview of the Ryan White Care Act Legislation and HRSA requirements as they relate to the Council's committee work and prioritization plan. | |
| | <i>Public Comment on this item</i> | |
| VIII. | Presentation on the San Francisco HIV Health Services Planning Council's Comprehensive Three Year Plan | 5:15 PM |
| | Brad Hume will provide an overview of the San Francisco HIV Health Services Planning Council's Three Year Plan, with specific focus given to how the Plan will fit into future prioritizations. | |
| | <i>Public Comment on this item</i> | |
| IX. | Committee Report -- Prioritization Planning Work Group -- Review and Approval of <u>Prioritization Plan and Schedule</u> -- VOTE | 5:30 PM |

The Prioritization Planning Work Group developed a plan for the Council's prioritization for FY03-04. A calendar includes suggested training topics and Council agenda activities through the end of August 2003. The proposal includes a request for approval of a Sub-category Summary Sheet Template.

Public Comment on this item

**X. Committee Report -- Co-Chair Report/Steering Committee --
Committee Structure/Function Plan -- VOTE**

5:45PM

The Council will vote to rearrange the current committee structure into five new committees, as listed below:

Committee 1

- Develop and oversee implementation of Comprehensive plan
- Prioritization strategies
- Assess disparities in service access/delivery
- Develop Unfunds/Rollover priorities
- Conduct and analyze needs assessments
- Provide regular presentations to the Council from local/national epidemiologists and researchers

Committee 2

- Monitor MOU between Council and AIDS Office
- Conduct Grantee Assessment
- Address grievances submitted to the Council
- Assure Council activities are in line with Council priorities
- Conduct Council policy/procedure assessments
- Oversee committee policy and procedures
- Oversee Unfunds/Rollover policies

Committee 3

- Evaluate effects of Council priorities/decisions (outcomes)
- Monitor implementation of Council priorities
- Assess impact of prioritization on health disparities
- Ensure that funding matches Council priorities

Committee 4

- Recruit/screen/train/retain Council members

Committee 5

- Community Action
- Coordinate programs with local prevention planners/providers
- Solicit consumer input
- Coordinate activities with other city, state, and national planning and advocacy groups

Public Comment on this item

Dinner Break

6:15 PM

**XI. Committee Report -- Membership Committee --
Recommendation of Appointment of Candidates -- VOTE**

6:30 PM

The Membership Committee will forward their recommendation to appoint Anita Booker to the HIV Health Services Planning Council for a term of two years commencing April 1, 2003.

Public Comment on this item

**XII. Presentation -- SFDPH, HIV Health Services Quarterly Report
& Update on FY03-04 CARE Award -- Michelle Long Dixon,
SFDPH, HIV Health Services**

6:35 PM

Michelle Long Dixon will provide the Council with a short presentation updating the Council on the current fiscal year's contracting and certification progress.

Public Comment on this item

**XIII. Committee Report -- Steering Committee -- FY03-04 CARE
Award Allocations -- VOTE**

7:00 PM

The Council proposes to use \$91,600 from the Title I FY03-04 award increase to augment the Planning Council support contract, as prioritized on February 13, 2003. HIV Health Services will use \$28,659 from the Title I FY03-04 award increase to prevent any cuts to current MAI funded contracts in the Treatment Adherence sub-category.

Public Comment on this item

XIV. Next Agenda

7:25 PM

Public Comment on this item

XV. Adjourn

7:30 PM

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Upcoming HIV Health Services Planning Council Meetings:

March 2003

Prioritization Planning Work Group	Tues. 25th	5:00-7:00	25 Van Ness Ave., Rm. 330A
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April 2003

Housing Committee	Wed. 2nd	3:00-5:00	25 Van Ness Ave., Rm. 330B
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Implementation & Evaluation Committee	Tues. 8th	3:00-5:00	25 Van Ness Ave., Rm. 330B
Prioritization Planning Work Group	Tues. 8th	5:00-7:00	25 Van Ness Ave., Rm. 330A
People Living with HIV Advisory Committee	Wed. 9th	5:30-7:30	25 Van Ness Ave., Rm. 330B
Community Action Committee	Thurs. 10th	4:00-6:00	25 Van Ness Ave., Rm. 330A
Membership Committee	Mon. 14th	4:30-6:30	25 Van Ness Ave., Rm. 330B
Steering Committee	Mon. 21st	5:00-6:30	25 Van Ness Ave., Rm. 330B
Prioritization Planning Work Group	Tues. 22nd	5:00-7:00	25 Van Ness Ave., Rm. 330A
HIV Health Services Planning Council	Mon. 28th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201

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HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

March 24, 2003
4:30 PM - 7:30 PM

MINUTES

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OCT 29 2003

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24/03
at

I. Call to Order

II. Roll Call (See Attachment A)

III. Review and Approval of Agenda

The agenda was moved and seconded.

IV. Review and Approval of Minutes, February 13, 2003

The minutes were moved and seconded.

V. General Announcements

- Catherine Geanuracos announced that an award letter was granted to Shanti for the new Council support contract. The review panel was very pleased with the proposal. She added that Tricia Turner is no longer going to be with the Council support staff after the end of this week.. All are meeting to arrange for the transition. All Sunshine Ordinance declarations are due to Tricia immediately.
- Kevin Johnson distributed a sign-up sheet for those who are interested in being a mentor to new members.

VI. Public Comment

- Bill Hirsh, of ALRP, congratulated the AIDS Office on their Title I CARE Award. This EMA received a small increase from last year's award. The group applauded Laura Thomas for her hard work, and she extended that praise to the Council and her co-workers at the AIDS Office.
- Dana Van Gorder encouraged any recipients of the ADAP program to join him in going to Sacramento to lobby to maintain funds on April 21, 2003. He can be reached at 487-3099. He also congratulated the Council on the CARE Award. The collaboration between Shanti, SFAF, and AHP is slated for a cut from the City's General Fund. The SFAF's Housing Subsidy program is going to need another \$170,000 from General Fund support. He was hopeful that the Council could help with this in any way.
- Clint Trout, of AIDS Healthcare Foundation, introduced himself and announced

they are hiring for an Outreach position.

- Patrick Monette-Shaw provided written public comment as follows: Prior to receiving this fiscal year's award notice, an e-mail distributed through this Council's Yahoo Group indicated notices had been sent out to San Francisco service providers in the bottom tier of service category priorities, advising them of planned de-funding. Now that this Council and the SF EMA have recently received notice of a small increase in this year's Ryan White CARE Act Title I award to the SF EMA, my question to you is whether the service providers who received de-funding notices last month have now been sent notices that at least some portion of their previous year's funding levels will be restored?

VII. Overview of Ryan White Care Act Legislation and HRSA requirements -- Laura Thomas, SF DPH HIV Health Services

Laura Thomas distributed a HRSA document, Priority Setting and Resource Allocation (See Attachment B). In preparation for this year's prioritization process, Laura Thomas asked the group to read this document along with the Ryan White CARE Act, the Shared Values section of the Three Year Plan and the FY03-04 Title I Grant Application. Laura reviewed the Priority Setting and Resource Allocation document. She stated that the greatest charge of the Council is to establish priorities for the allocation of funds and how best to make those allocations. HRSA also expects the Council to consider the size and demographics of people living with HIV (epi data), the needs of the population (consumer input, Needs Assessments, Community Forums), cost effectiveness (AIDS Office Summary Sheets), the priorities of consumers (consumer input, Needs Assessments, Community Forums), coordination of programs and funding streams (Summary Sheets, recipients of other Titles, Three Year Plan), capacity development (community needs), and determining who is not-in-care.

To write the Title I grant application, Laura Thomas needs a list of service sub-categories in their priority order, and the amount of money to be allocated to each sub-category. In addition, the Council can give HHS directives on how to spend that money (e.g. service populations, etc.). The Three Year Plan takes this into consideration. The Council must be completed with their priority decisions by the end of August. Laura added that sub-categories are used because the Council is not allowed to speak about specific agencies. Mjay Sanders stated that this document will be helpful, particularly to new members.

Public Comment on this item

There was no public comment on this agenda item.

VIII. Presentation on the San Francisco HIV Health Services Planning Council's Comprehensive Three Year Plan

Catherine Geanuracos mentioned that the Three Year Plan includes a great overview of the Council's goals and objectives, shared values and general

epidemiological data. Even though the award for this year was increased slightly, future funding reductions are still very possible. In the Goals and Objectives portion of the Three Year Plan, timelines for progressing through the next three years are included. There are repeated references to people who are not-in-care, and eligibility criteria. One of the directives from HRSA is to address disparities in healthcare. The Three Year Plan acknowledges this and attempts to address this issue. The Plan also touches on sub-category issues, and Planning Council functions. The goals ask the Council to assess for the first year, make changes accordingly in the second year, and evaluate in the third year. As such, this document should guide the Council in their prioritization this year.

Susan Shea asked how the \$1.8 million cut is going to be addressed while being consistent with the Three Year Plan. Laura Thomas clarified that from FY01 to FY02 there was over a \$2.2 million cut, and that reduction was supplemented by the Board of Supervisors backfill and one-time rollover dollars. As such, this year's increase is from the baseline, not including those supplemental dollars. Margot Antonetty stated that the cut was already made in FY01, and any supplement to the base is irrelevant when speaking of an increase. Susan Shea suggested that the Three Year Plan may need to be tweaked to be consistent with the three year tier prioritization decisions made last year. Catherine Geanuracos stated that the goal is to maintain all of the service categories, but also to maintain essential services. Susan Shea stated that the document is very idealistic, and asked that the Council revise the plan if it is a living document. Laura Thomas stated that the Plan can be modified, but it is important to keep in mind that it is a plan which does entail a certain amount of idealism. Mjay Sanders stated that the document is a very useful document, a starting point to move forward. Larry Cruz asked about the specific goal regarding prevention for positives, and if this would be within the purview of the Prevention Council. Catherine Geanuracos stated that the goal speaks to collaboration with the Prevention Council and provides support for contractors to attend prevention trainings. Mary Lawrence Hicks, of the AETC, reported that interest is growing surrounding prevention for positives.

Public Comment on this item

Jim Hlig, of Project Open Hand, stated that clients and agencies did not feel the cut from last year because of the backfill and rollover. This year, all will feel the cut, especially with the reductions from the General Fund. He warned the Council in planning around coordinating agencies, as referenced in the Three Year Plan's Goals and Objectives. Brad Hume replied that the focus of the Three Year Plan is to create "centers of excellence", where the hub is Primary Care surrounded with relevant services. The Prioritization Planning Work Group is working on defining what a "center of excellence" would look like.

Walter Miller Jr., of the Oakland Planning Council, asked the Council how they compiled this Three Year Plan. Catherine Geanuracos replied that a small work group met regularly, and consulted the PLWH Advisory

Committee on several occasions.

IX. Committee Report -- Prioritization Planning Work Group -- Review and approval of Prioritization Plan and Schedule -- VOTE

The Prioritization Planning Work Group developed a plan for the Council's prioritization for FY03-04 (See Attachment C). A calendar includes suggested training topics and Council agenda activities through the end of August 2003. Catherine Geanuracos proposed that the Council include the outcome to have three scenarios for increased or reduced funding (as was done last year). The proposal includes a plan to carry over most of last year's prioritization process, while keeping into consideration changing funding realities and other relevant factors. The Council would be meeting only once during the summer, but will have the day-long meeting in August. The May meeting will be held on the following Tuesday. A document was distributed (See Attachment D) that would align the Council's sub-categories with HRSA's sub-categories. This proposal will be voted on at the next full Council meeting.

Outcome: The motion unanimously passed.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows: This proposed process schedule indicates this Council will compare next August last summer's category summary sheets to new summary sheets, to analyze two years of funding decisions. Last July's summary sheets, which looked at FY '01-'02 service category utilization data, specifically stated in the summary sheets -- or in an introduction -- that there were flaws in that data, including service utilization data. Those summary sheets last summer also mixed apples and oranges by comparing multiple FY data, rather than data from a single FY. Using that flawed data, this Council set the current FY's service priorities. Before you compare next August the cross-year service utilization data, you should require that the Grantee (SF DPH), provide you with an accurate updated revision to last year's flawed summary data sheets. Otherwise, you will continue to compare apples to oranges, and PLWHA will be shortchanged by your faulty cross-year analysis.

X. Committee Report -- Co-Chair Report/Steering Committee -- Committee Structure/Function Plan -- VOTE

Brad Hume stated that the Steering Committee reviewed a list of activities that Council committee's are responsible for (See Attachment E). Each committee was sectioned into five separate committees, outside of Steering Committee. Brad Hume explained that some of these committees may still have a need for ad hoc groups (e.g. Grantee Assessment Task Force). He added that there is no specific Housing Committee or PLWH Advisory Committee included in this proposal. The Housing Committee is the only committee that handles a specific sub-category. The Committee 5 would include several responsibilities that are currently handled by the PLWH

Advisory Committee. Donald Frazier stated that Committee 1 basically is a planning group, Committee 2 would implement, and Committee 3 would evaluate. The Steering Committee would continue carrying out its logistical responsibilities. Randy Allgaier asked about implementing this committee structure. Catherine Geanuracos replied that this should wait until after the transition of Council support. Jeff Byers stated any change in the bylaws be notified appropriately with 30 days notice. He added that it is difficult for him to digest that the PLWH Advisory Committee would not continue. Randy Allgaier stated that he supports the idea of positive people being incorporated into the other committees. Thus, the positive voice would be spread around instead of confined to just one committee. Margot Antonetty stated that the Housing Committee was developed because of such a great need for the Council to address these issues. The idea was to develop such committees for other service sub-categories, but they never continued as long as the Housing Committee did.

The Bylaws change will be voted on next month. Kevin Johnson called the question.

Outcome: The motion passed unanimously.

Public Comment on this item

There was no public comment on this agenda item.

Dinner Break

XI. Committee Report -- Membership Committee -- Recommendation of Appointment of Candidates -- VOTE

The Membership Committee made a recommendation to appoint Anita Booker to the HIV Health Services Planning Council for a term of two years commencing April 1, 2003. Anita Booker works for San Mateo County and will represent the AIDS Community Research Consortium.

Outcome: With 2 oppositions, the motion carried.

Public Comment on this item

There was no public comment on this agenda item.

XII. Presentation -- SFDPH, HIV Health Services Quarterly Report & Update on FY03-04 CARE Award -- Michelle Long Dixon, SFDPH, HIV Health Services

Michelle Long Dixon introduced Jimmy Loyce, Deputy Director of Health in San Francisco. Jimmy Loyce mentioned the passing of Alfonso Acampora, Founder and President of Walden House. Donald Frazier, Director of

Contracts and Compliance of Walden House, added that Alfonso will be sorely missed and the agency is grieving. Services are scheduled for later in the week for his family. A memorial inviting the community will be held later on.

Jimmy Loyce added that DPH has been asked to draft a proposal for a \$40 million contingency cut, and was able to come up with a \$16 million reduction. The Health Commission agreed that even a \$16 million dollar contingency cut would be detrimental to health services in San Francisco. On April 8, 2003 the Health Commission will most likely reject the proposal and send that reduction to the Mayor's Office.

Michelle Long Dixon distributed the HIV Health Services' quarterly report (See Attachment F). She reviewed the document. The Title I award (including a small increase) for FY03-04 totaled \$33,941,235. Michelle Long Dixon reported that contractors have been notified that cuts will be restored because cuts were not necessary. Because last fiscal year's contracting process occurred so late in the year, Program Managers will be renewing contracts, and modifications will be processed later as needed.

The document includes detail of the allocations for solicitation for unobligated funds. At the end of the prior fiscal year, a contract was identified that was leaving money on the table. HHIS used the money for vouchers for household goods and food. Shanti was awarded the Planning Council Support contract; negotiations are in process.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows: Voucher money was identified after the solicitation went out. Michelle Long Dixon is not aware of any other unobligated funds.

XIII. Committee Report -- Steering Committee -- FY03-04 CARE Award Allocations -- VOTE

Russ Zellers distributed the CARE Title I Award document (See Attachment G). Catherine Geanuracos explained that at the last prioritization, the Council decided to maintain the top tier of services, and cuts would be made from the bottom of the service sub-category list up. At the February Council meeting, the group agreed to augment the Council support contract.

Though the FY03-04 CARE award was increased, the MAI funding amount was unfortunately reduced. At the last prioritization, the Council had decided to prioritize a \$50,000 solicitation for Spanish-speaking Substance Use services from MAI funding. The only currently MAI funded program is Treatment Adherence and Outreach (\$38,828). Steering Committee made a proposal to maintain this current program, and not pursue the solicitation process to accommodate the cut. A proportional increase was allocated to San Mateo and Marin. Jim Illig asked why only San Francisco (not Marin and San

Mateo) is paying to maintain the Planning Council support and the Treatment Adherence. All agreed that it was the intent of Steering Committee to take the money off the top of the entire increase (before increases are awarded to the other counties) to maintain the MAI funding and Planning Council augmentation.

Ken Pearce has concerns that the top tier prioritization being based on the idea that funding is going to be reduced can be problematic, especially when looking at the amounts allocated to certain top tier service sub-category. Michelle Long Dixon stated that the unobligated solicitation was open to the top tier.

Steering Committee proposed to use \$91,600 from the total Title I FY03-04 award increase (before the increase is awarded to the other counties) to augment the Planning Council support contract. HIV Health Services will use \$38,828 from this Title I FY03-04 award increase to prevent any cuts to current MAI funded contracts in the Treatment Adherence sub-category.

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows: The Ryan White CARE Act Title I application competition included a known three percent cut in the formula portion of the San Francisco EMA's '03-'04 award. How can it be San Francisco just received a modest increase to its overall award above last year's funding - given known violations of federal conditions of award by the SF Grantee, including Sunshine Ordinance open meeting violations, excessive delays in issuing contracts to service providers, and the carry-forward of unspent funds from the previous fiscal year, among others? How did violative San Francisco prevail, competitively, ahead of other jurisdictions, earning SF an increased award? A reasonable person wonders just how low HRSA's competitive standards were in awarding SF additional funds above the known three percent formula cut, ignoring SF's violations of federal guidance. More properly, HRSA should have competitively rewarded other jurisdictions that did not violate federal conditions of award. Did political connections prevail?

Outcome: The motion carried.

XIV. Next Agenda

Public Comment on this item

XV. Adjourn

Meeting minutes are considered to be in DRAFT form until reviewed and approved by Council attendees.

[Home](#) | [Community Outreach & Advocacy Committee](#) | [Infrastructure & Policy Committee](#) | [Evaluation Committee](#)
[Membership Committee](#) | [Planning Committee](#) | [Steering Committee](#)

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

DOCUMENTS DEPT.

April 28, 2003
4:30 PM - 7:30 PM

OCT 29 2003

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DRAFT AGENDA

- | | | |
|------|--|---------|
| I. | Call to Order | 4:30 PM |
| II. | Roll Call | 4:32 PM |
| III. | Review and Approval of Agenda | 4:34 PM |
| IV. | Review and Approval of Minutes, <u>March 24, 2003</u> | 4:36 PM |
| V. | General Announcements | 4:40 PM |
| VI. | Public Comment | 4:45 PM |
| VII. | Presentation -- San Francisco Sunshine Ordinance -- Ann Alpers, Deputy City Attorney | 5:00 PM |

Ann Alpers, Deputy City Attorney for the City of San Francisco, will provide a presentation to Planning Council members regarding the San Francisco Sunshine Ordinance as it pertains to the Planning Council. The presentation will include discussion on specific areas of the law pertaining to open meetings, agendas, minutes, public comment, etc.

Public Comment on this item

- | | | |
|-------|---|---------|
| VIII. | Presentation -- Epidemiology of the AIDS Epidemic in San Francisco County -- Susan Scheer, HIV Statistics & Epidemiology Section -- SFDPH | 5:30 PM |
|-------|---|---------|

Susan Scheer, from the HIV Statistics & Epidemiology Section of the San Francisco Dept. of Public Health, will provide a presentation to the Planning Council of the HIV epidemic in San Francisco.

Public Comment on this item

- | | | |
|----|---------------------|---------|
| X. | Committee Report -- | 6:15 PM |
|----|---------------------|---------|

Bylaws Change Vote Notification -- Vote to occur at May 27, 2003 HIV Health Services Planning Council meeting.

The HIV Health Services Planning Council is required to provide 30 days notice of a vote that results in changes to the Council's written Bylaws. The changes to the Bylaws the Planning Council will consider may be viewed on the following attachment of the **Council's Bylaws**. The Council intends to discuss and vote on the changes at the May 27, 2003 HIV Health Services Planning Council meeting.

Co-Chair Report/Steering Committee Committee Structure/Function Plan

The Steering Committee proposes to arrange the Planning Council's committee structure into six committees, as described below.

Steering Committee

- Set agenda for Council meeting
- Coordinate committees' work
- Address grievances submitted to the Council

Planning

- Develop and oversee implementation of Comprehensive plan
- Prioritization strategies
- Assess/address disparities in service access/delivery
- Develop Unfunds/Rollover priorities
- Conduct and analyze needs assessments
- Provide regular presentations to the Council from local/national epidemiologists and researchers

Implementation

- Monitor MOU between Council and AIDS Office
- Conduct Grantee Assessment
- Conduct Council policy/procedure assessments
- Oversee Unfunds/Rollover policies
- Oversee committee policy and procedures

Evaluation

- Monitor implementation of Council priorities
- Evaluate effects of Council priorities/decisions (outcomes)
- Ensure funding matches Council priorities
- Assure Council activities are in line with Council priorities

Membership

Recruit/screen/train/retain Council members

Community Outreach/Advocacy

- Community Action
- Coordinate programs with local prevention planners/providers
- Solicit consumer input
- Consumer Rights Advocacy Project
- SRO Task Force

Note: Committee names are suggestions; committees may choose a different name if they feel it better represents their work.

Public Comment on this item

Dinner Break**6:30 PM****XI. Committee Report -- Membership Committee --
Recommendation of Appointment of Candidate -- VOTE****6:45 PM**

The Membership Committee will forward their recommendation to reappoint Donald Frazier to the HIV Health Services Planning Council for a term of two years commencing June 1, 2003.

Public Comment on this item

Planning Council Membership Policy & Procedures -- VOTE

The Membership Committee makes the motion that the Planning Council adopt the attached Policy & Procedures for Planning Council membership

Public Comment on this item

XII. Presentation -- SFDPH, HIV Health Services Report -- Michelle Long Dixon, SFDPH, HIV Health Services**7:00 PM**

Michelle Long Dixon will provide the Council with a short presentation updating the Council on the current fiscal year's contracting and certification progress.

Public Comment on this item

XIII. Committee Report -- Steering Committee, Cont'd**7:05 PM****Change of Meeting Date for May**

The Planning Council will move its May meeting to Tuesday, May 27, 2003 because of Memorial Day. The Planning Council will return to its regular meeting schedule in June.

Service Categories -- VOTE

The Steering Committee makes a motion for approval by the full Council to realign/reword the San Francisco EMA's service category nomenclature to bring such language into better alignment with the service category reporting required by HRSA (the Grantor.) The attached chart shows how the service category names will be affected. Please note that this change in naming convention will have no impact on service delivery, nor will it alter service category prioritization.

Public Comment on this item

Prioritization Process -- VOTE

The Steering Committee makes a motion for approval by the full Council to readopt the Prioritization Process debated and approved during their Fiscal Year 2003-04 Prioritization Process. The motion refers to the ranking of services categories currently being implemented by the SFDPH, as well as the reduction scenarios approved during the prioritization process. The process the Steering Committee is asking the Council to reaffirm is contained in the language of the August 26, 2002 and September 23, 2002 meeting minutes.

Public Comment on this item

XIV. Next Agenda**7:25 PM**

Public Comment on this item

XV. Adjourn**7:30 PM**

*Note: Agenda items are subject to change, postponement, or removal.
Meeting agendas are considered to be in DRAFT form until reviewed and approved by Council attendees.*

973 Market Street, 6th Floor, San Francisco, CA 94103

San Francisco Department of Public Health, AIDS Office

25 Van Ness Avenue, 5th floor, San Francisco, CA 94102

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The following services are available when requested by Noon of the Friday before the Council meeting:

For American Sign Language interpreters, use of a reader during a meeting, or sound enhancement system, contact Tricia Turner at (415) 972-0870. For a large print copy of agenda or minutes in alternative format, contact Tricia Turner at (415) 972-0870.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products.

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The Planning Council has several standing Committees where Council business and creation of motions for full-Council action occur, and members of the public are urged to attend. Council procedures do not permit: 1) persons in the audience at Council meeting to vocally express support or opposition to statements by Council members or by other persons testifying, outside of public comment; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the co-chairs of a Committee or to Council members, c/o HIV Health Services Planning Council, 973 Market Street, 6th Floor, San Francisco, CA 94103. Agendas are available on the internet at <http://www.dphs.sfgov.us/Meetings/meetings.htm>. THE AGENDA PACKET IS AVAILABLE FOR REVIEW AT HIV Health Services Planning Council, 973 Market Street, 6th Floor, San Francisco, CA 94103 RECEPTION DESK.

Upcoming HIV Health Services Planning Council Meetings:

May 2003*

Prioritization Planning Work Group	Tues. 6th	5:00-7:00	25 Van Ness Ave., Rm. 330A
Membership Committee	Mon. 12th	4:30-6:30	25 Van Ness Ave., Rm. 330B
Steering Committee	Mon. 19th	5:00-6:30	25 Van Ness Ave., Rm. 330B
HIV Health Services Planning Council	Tues. 27th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201

Home | Community Outreach & Advocacy Committee | Infrastructure & Policy Committee | Evaluation Committee
Membership Committee | Planning Committee | Steering Committee

* The Planning Council is currently evaluating its Committee Structure... Please check the Planning

Council's website at the end of April for information regarding Committee meetings, dates, and times.

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

April 28, 2003
4:30 PM - 7:30 PM

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- I. Call to Order
- II. Roll Call (See Attachment A)
- III. Review and Approval of Agenda

The agenda was moved and seconded.

- IV. Review and Approval of Minutes, March 24, 2003.

Review and Approval of Minutes of March 24, 2003.

- V. General Announcements

Catherine Geanuracos announced that Eric Whitney has left his position as Executive Assistant. Shanti support staff, Hywel Sims, Executive Director, and Jessica Berman, Executive Assistant, were introduced. Brad Hume and Catherine Geanuracos briefly discussed the transitional nature of this time.

John Conley expressed sincere thanks to all council members.

Randy Allgaier and Lara Sallee are going to Washington, D.C. and will report back to the committee.

- VI. Public Comment

Jessica Bowen introduced herself and two other individuals. Kris Popplewell and Jason Vaudrey, who are in the Masters in Public Health Program at San Francisco State University. They are conducting a needs assessment for HIV+ San Francisco youth aged 16 to 24 via one on-one interviews, and would appreciate any input from the council. (They handed out an information sheet with a way of contacting all three researchers.) They will present their findings in late Fall.

- VII. Presentation: San Francisco Sunshine Ordinance – Ann Alpers, Deputy City Attorney

Ann Alpers handed out the 35-page handbook on Sunshine Ordinance Training for San Francisco Public Officials (February, 2002) and made a 15-minute presentation, with ongoing discussion.

Ann Alpers stated that one main rule is that a meeting occurs when a quorum, or the majority of a policy body, is met. A policy body is any commission, board or council appointed by the City and County of San Francisco.

Catherine Geanuracos commented on the method of dissemination of information and how a member of the public knows to attend a meeting.

There are rules on the public's right to speak, with very few exceptions – e.g. earthquakes and other emergencies. Clarification sought by Catherine Geanuracos. Ken Pearce and Brad Hume commented on the importance of this.

Discussion ensued on how to handle disruptive behavior at meetings on the part of the public. Catherine Geanuracos commented that it only happened once at a Council meeting and spoke of Council rules and regulations. Mark Dunlop spoke of the Brown Act. Mark Dunlop and Ann Alpers had a give-and-talk about this. Donald Frazier suggested that these be reviewed in the Policies and Procedures.

Public Comment on this item

Jim Dille of Project Open Hand commented about not seeing something in the written materials. Ann Alpers clarifies policies and how they are decided upon vis a vis legislation. Mark Dunlop asked for clarification on two points about the Sunshine Ordinance.

In response to a question about public comment on agenda items, Ann Alpers recommended that comments made at meetings be specific to the topic. However, public comment can, according to the rules, deviate from this.

Catherine Geanuracos commented that generally the council has "a relaxed attitude in our meetings". Donald Frazier commented on that.

A member of public asked how a meeting would proceed if it did not have a quorum. Catherine stated that in the case of this council, invariably a quorum is reached at each meeting. Kevin Johnson reiterated this point.

Ann Alpers, presenter, addressed the issue of the consequences of taking formal action(s) without the presence of a quorum. A member of the public brought up "alternates" and how they can serve in ensuring there is a quorum.

Patrick Monette-Shaw provided written public comment as follows.
"Last fall, a contractor specializing in parliamentary procedure presented training on Roberts Rules of Order to this CARE Council. He encouraged Council members to use e-mail freely, and his encouragement is available on

that meeting's audiotape.

I have seen e-mails posted on the Council's Yahoo Groups site that refer to other e-mails which appear to have been sent through systems other than the Council's Yahoo Group. How can the public be assured that this Council is not conducting seriatim meetings by using several different e-mail systems, or blind-copy distribution to restricted e-mail lists, and therein is violating the San Francisco Sunshine Ordinance by discussing Council business in private e-mails?"

Kevin Johnson mentioned that planning is sometimes done via e-mail.

Ken Pearce asked if a quorum is 50% of the members. Catherine Geanuracos replied that it is 50% or five HIV+ individuals. Kevin Johnson also clarified the rules. Donald Frazier suggested that the Policies and Procedures be revisited for clarification with regard to quorums. Mark Dunlop made a comment on this point. Ken Pearce asked again about quorums. Ann Alpers replied, and the presentation came to a close.

VIII. Further Announcements

Catherine Geanuracos stated that a joint meeting was being planned to have prevention measures, as well as needs assessment activities, for HIV+ individuals. There is also collaboration/participation of prevention council members on training. Jeff Byers sought clarification and Catherine Geanuracos replied. She will update members as this joint meeting on prevention and needs assessment moves forward.

Ken Peace suggests that meeting times and dates be published so that there is no conflict.

Public Comment on this item

Jim Illig, of Project Open Hand, stated that clients and agencies did not feel the cut from last year because of the backfill and rollover. This year, all will feel the cut, especially with the reductions from the General Fund. He warned the Council in planning around coordinating agencies, as referenced in the Three Year Plan's Goals and Objectives. Brad Hume replied that the focus of the Three Year Plan is to create "centers of excellence", where the hub is Primary Care surrounded with relevant services. The Prioritization Planning Work Group is working on defining what a "center of excellence" would look like.

Walter Miller Jr., of the Oakland Planning Council, asked the Council how they compiled this Three Year Plan. Catherine Geanuracos replied that a small work group met regularly, and consulted the PLWH Advisory Committee on several occasions.

IX. Presentation: Epidemiology of the AIDS Epidemic in San Francisco

County – Susan Scheer, HIV Statistics and Epidemiology Section, SFDPH (See supplement)

Definitions were presented. She said that the prevalence of HIV in MSM is approximately 20%, and as of the end of last month there were 9000 HIV cases in San Francisco. The information gathered was from patients in the field as well as from the clinicians' reports in medical records. Case reporting was collected, except they have a considerable backlog. They collected the data, but also supplemented this with UCSF research data, and sampling the UCSF clinics. They had a strength in that a form to gather data was consistent across the nation. A weakness was lacking resources to gather information.

Several slides were shown:

- Trends in AIDS Incidence, Mortality and Prevalence as of March 31, 2003 [White men were most common 10+ years ago; now, black men are more common.]
- Female Annual AIDS Incidence – rates per 100,000 by race/ ethnicity. [Duk Doepfner commented that there is an observable difference; Anthony Huynh asked about Asian statistics, which were negligible, Kevin Johnson asked about transgenders, which Scheer addressed. A given clinician may interpret an individual to be a different gender than how the individual identifies herself/himself. Donald Frazier asked about statistics on African-American women– and Susan Scheer said that there are greater risk factors.]
- History of HIV Incidence, San Francisco [the peak was in 1992].
- Sexual Risk Behaviors Among MSM. [Ken Peace asked about the 2002 and 2003 data – it, as yet, is not yet processed.]
- Cases of Primary or Secondary Syphilis and Male Rectal Gonorrhea, MSM. [Jeff Byers confirms that these are city statistics rather than state. Keith brings up the example of Indiana.]
- HIV Incidence among MSM Seeking HIV Testing.
- Characteristics of Individuals Living with AIDS.
 - Race/Ethnicity of Persons Living with AIDS Compared to the San Francisco's General Population, March 31, 2003. [Keith and Darnell had questions, which were addressed. Jeff Byers asked if this was part of the 9000. It was 900 individuals in that particular study. Patrick Monette-Shaw, a member of the public, commented that it was like comparing oranges with apples; he asked what sorts of tests were given and Susan, presenter, said what they were.]
- AIDS Cases by Gender and Insurance Status, San Francisco, 1997-2002.

Private versus Public [Randy A. determines this is at the time of diagnosis.].

- Proportion surviving three years after AIDS Diagnosis, by Gender, San Francisco, 1993-1999.

- Proportion surviving three years after AIDS Diagnosis, by Race, San Francisco, 1993-1999.

- Proportion surviving three years after AIDS Diagnosis, by Risk, San Francisco, 1993-1999 [injection drug users].

- Characteristics of Homeless Persons with AIDS, San Francisco, 1993-2002.

- Proportion Surviving three years after AIDS diagnosis by Homeless Status, San Francisco, December, 2002.

- Map: Estimated Proportion Surviving five years after AIDS Diagnosis.

- Map: HAART Use by Neighborhood, 1996-2000

Public Comment on this item

Patrick Monette-Shaw provided written public comment as follows:
 "The last San Francisco Consensus Meeting report was dated and distributed six years ago in 1997. Our missing-in-action AIDS Czar's (Mike Shriver's) Consensus Meeting 2001 held in January and February 2001 issued a pathetic 14-page PowerPoint summary – an abridged report – without ever completing editing of the 90-to-150-page unabridged Word document, despite having obtained public comment on it. The CARE Act requires HIV case-reporting by 2004, I believe. Susan Scheer just reported to this Council that HIV case reporting is yielding spotty data due to "passive reporting" of new HIV infections by healthcare providers, and that DPH has not yet analyzed preliminary data as it is unrepresentative of suspected trends. DPH's foot dragging in analyzing HIV unique-identifier reporting to accurately estimate HIV incidence is placing San Francisco's receipt of CARE Act funds in jeopardy, possibly resulting in a significant cut of CARE funds to San Francisco 12- to 24-months from now."

There was further discussion about the implications of the data, including about individuals not in care. Susan Scheer reiterated that they have a formidable backlog of data, which is to be worked on within the next 18 months. Catherine Geanuracos reminded council members that Ms. Scheer can be emailed with further questions.

X. Bylaws Change Vote Notification (Vote to occur at May 27, 2003 HIV Health Services Planning Council meeting)

Committee Report by Co-Chair Brad Hume on Committee Structure/Function Plan-- VOTE

Brad Hume stated that the Grievance and Appeals Article VII has been the way it has been done for years. Catherine Geanuracos concluded that there would be no more discussion on this item. Anthony Huynh asked if this refers to individuals not in the EMA. Lara Sallee clarified the rules. Mark Dunlop said that this was a restatement of what HRSA has put forward. He added that this is to be a "living document, which we will alter as we need to", as part of the membership's Policies and Procedures. He stated that this would be a straightforward and easy process.

Catherine called for the VOTE: Passed.

Choosing of Committees:

- IMPLEMENTATION
- PLANNING
- MEMBERSHIP
- COMMUNITY OUTREACH PLANNING
- EVALUATION

People picked committees. (See attachment for list of co-chairs, committee participants, and first meeting times.)

Catherine Geanuracos announced that there must be HIV+ representation on each committee.

Brad Hume reminded people to write when their initial meeting is to take place. Times and dates are indicated on each sign-up sheet.

Public Comment on this item

There was no public comment on this agenda item.

Dinner Break

XI. Committee Report -- Membership Committee -- Recommendation of Appointment of Candidates -- VOTE

VOIE: Mark Dunlop reappoints Donald Frazier to the HIV Health Services Planning Council. Unanimous reappointment

Public Comment on this item

There was no public comment on this agenda item.

XII. Planning Council Membership Policy & Procedures

Kevin Johnson talked about Membership Bylaws, with Mark Dunlop adding to the information. Anthony Hunyh commented. Kevin Johnson spoke about procedures from interaction. Brad Hume stated he does not see the committee co-chairs included in the sentence. Kevin Johnson pointed to it.

Donald Frazier pointed out that reimbursement was always included in the Bylaws.

Probation was discussed. It is thought to be a consequence of resignation from council, and the probation period is to be determined (if missed three meetings in the past, sent letter/contacted, 2nd letter/contact, 3rd letter/contact considered resignation).

Rather than a set time period, there is essentially a warning. Once one has attended a meeting, then probation is lifted. Because there is a quarterly review, there is no need to determine a time period.

Brad Hume stated that this is a process that was used in the past, but this was the first time it has been put in writing. He stated that the point was to encourage people to change their attendance patterns.

Residence requirement: wording from HRS/A, requirement some have to be a resident some here Lara Sallee clarified that because who you work for must work in the EMA, or representing community must live in EMA. The exception was a Council member xx who works for the State (he lives in Sacramento)

Mark Dunlop puts forward the reasons he wrote and presented the document. This living document can be changed and amended as needed, because it is not part of the Bylaws.

Mark Dunlop calls for a vote.

CONSENSUS: Unanimous.

Catherine commended committee for their hard work.

Public Comment on this item

For people who live outside of the EMA, it was suggested that it might be a good idea to have them participate in councils in other areas and therefore they would be represented. Catherine recommended membership.

XIII. Presentation – SFDPH, HIV Health Services Report – Russ Zellers for Michelle Long Dixon, SFDPH, HIV Health Services

(See blue handout – updates contract of March.)

Many contracts will be opened for negotiation in the next few months.

Susan Shea asked that if money that had to be in by 28th was spent, Russ Zellers did not know if the money was spent, but stated all was certified.

Russ Zellers was asked if all the award letters went out. Russ believed that Pat sent renewal letters out at beginning of the process. Catherine was asked if it was better than last year. Russ said that it was, but many will need to be opened up and renegotiated.

Public Comment on this item

There was no public comment on this agenda item.

XIV. Committee Report – Steering Committee

Prioritization Process:

The chart – Proposal for Revised Service Categories for Fiscal Year 2003-04-- was referred to.

Steering committee had recommended that the sub-categories match up with HRSA's (see attached chart). Note: Food can be in both HPPC food categories. There was much discussion in the steering committee about how this will affect prioritization. Steering committee moved for approval by the full council.

Specific recommendations will be made to AIDS Office on how to allocate money within each category. The majority of subcategories would not be affected. The goal was to have a streamlined process that would be most compliant with HRSA's guidelines and would bring San Francisco in line.

Tiers would be created and perhaps a few categories could be dispensed with. New priority ranking would be reviewed. For example, new outreach would be not ranked, and first 11 would more or less stay the same. However, some would be combined. Catherine suggested that second and third be split at a different point for the top tier.

Ken Pearce asked about the food category. Susan Shea clarified this. At this point, congregant meals are now in the third tier, in third place, and if this were changed this would affect the percentage in the food category.

In this structure, sub-category summary sheets that describe services in each category become more important. Therefore, recommendations can be made by the council within categories and subcategories, and this can be very specific, even in terms of respective dollar amounts. Specificity of dollars with knowledge of Health Department rules will be optimally balanced.

Ken Pearce stated that there will need to be “clear consistency with sub-categories to avoid confusion”, and pointed out that the previous year some items were combined. Mental health, for example, was in one, two and three, but now it is in one sub-category. In terms of institutional memory, he stated it would be best to write all the details down. Some discussion took place around this.

Catherine Geanuracos thought it would be good to look at each sub-category with more specificity in terms of allocation of specific services.

Randy Allgaier stated that when you look at this process year to year, similarities will be seen and decisions can be made more smoothly. Last year’s experience will give form to this year’s.

There were no more questions from Steering Committee, and discussion was finished on this subject, after which a vote was taken.

VOTE: All steering committee recommendations passed, with one abstaining (Dirk Doepfner).

Public Comment on this item

Lorna of San Francisco Board of Directors, AIDS Foundation, had some concerns about low priority of childcare. This was deferred and would be discussed outside of meeting – Catherine made herself available for this. However, childcare constituted its own category and would remain so

Patrick Monette-Shaw sought clarification about how sub-categories were being looked at
Catherine Geanuracos clarified that comparisons are being made between last year and this year

XV. Next Agenda

XVI. Adjourn

Meeting minutes are considered to be in DRAFT form until reviewed and approved by Council attendees.

Home | Community Outreach & Advocacy Committee | Infrastructure & Policy Committee | Evaluation Committee
Membership Committee | Planning Committee | Steering Committee

- San Francisco

HIV Health Services Planning CouncilCity Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett PlaceMay 27, 2003
4:30 PM - 7:30 PM**DRAFT AGENDA**

- I. Call to Order**
- II. Roll Call**
- III. Review and Approval of Agenda** 4:35 PM
- IV. Review and Approval of Minutes, April 28, 2003** 4:40 PM
- V. General Announcements** 4:45 PM
- VI. Public Comment** 4:55 PM
- VII. Presentation -- Reggie Data Demographics—DPH Staff** 5:05 PM

Presentation by DPH staff on the demographics and characteristics of client data from the Reggie system.

Public Comment on this item

- VIII. Presentation: San Mateo County Update- San Mateo County AIDS Program Staff** 5:35 PM

Summary of current state of HIV epidemic in San Mateo county -- demographics of people living with HIV, overview of services provided, current needs and county-based planning summary.

Public Comment on this item

- IX. Presentation: Marin County Update - Marin County AIDS Program Staff** 5:50 PM

Summary of current state of HIV epidemic in Marin county -- demographics of people living with HIV, overview of services provided, current needs and county-based planning summary

Public Comment on this item

X. By-Law Change -VOTE

6:10 PM

To make changes to the by-laws per the recommendations in the attachment to this agenda

Public Comment on this item

XI. Dinner Break

6:15 PM

XII. Presentation: Review of Previous Needs Assessment Data/ Report- Michael de Mayo of LaFrance Associates

6:30 PM

Michael DeMayo of LaFrance Associates will summarize the results of the most recent full needs assessment report, and provide a guide to reading and understanding the needs assessment results.

Public Comment on this item

XIII. Review/Approve the planned allocation of FY03-04 Title I grant funds -VOTE

6:45 PM

Approve the allocation of FY 03/04 Title I grant funds

Public Comment on this item

XIV. Update: AIDS Drug Assistance Program Jeff Byers, California State Office of AIDS

6:55 PM

Brief summary of state-level budget planning for potential ADAP cuts/ co-payment requirements.

Public Comment on this item

XV. Committee Reports - Membership

7:00 PM

Public Comment on this item

XVI. Committee Reports - Infrastructure and Policy

7:06 PM

Report on Committee's development of mission statement, current and future tasks, and interim co-chair elections.

Public Comment on this item

XVII. Committee Reports - Evaluation

7:12 PM

Report on Committee's development of mission statement, current and future tasks, and interim co-chair elections.

Public Comment on this item

XVIII. Committee Reports - Community Action

7:18 PM

Report on Committee's development of mission statement, current and future tasks, and interim co-chair elections.

Report back from CAEAR Coalition Meeting

Public Comment on this item

XIX. Committee Reports - Planning

7:24 PM

Report on Committee's development of mission statement, current and future tasks, and interim co-chair elections.

Public Comment on this item

XX. Next Agenda

7:29 PM

Public Comment on this item

XXI. Adjourn

7:30 PM

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HIV Health Services Planning Council

730 Polk St, 3rd Floor, San Francisco, CA 94109

San Francisco Department of Public Health, AIDS Office

25 Van Ness Avenue, 5th floor, San Francisco, CA 94102

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Upcoming HIV Health Services Planning Council Meetings:

June 2003

Prioritization Planning Work Group	Tues. 6th	5:00-7:00	25 Van Ness Ave., Rm. 330A
Membership Committee	Mon. 12th	4:30-6:30	25 Van Ness Ave., Rm. 330B
Steering Committee	Mon. 19th	5:00-6:30	25 Van Ness Ave., Rm. 330B
HIV Health Services Planning Council	Tues. 27th	4:30-7:30	City Hall, Mayor's Conf. Rm. 201

Home | Community Outreach & Advocacy Committee | Infrastructure & Policy Committee | Evaluation Committee

Membership Committee | Planning Committee | Steering Committee

* The Planning Council is currently evaluating its Committee Structure... Please check the Planning Council's website at the end of April for information regarding Committee meetings, dates, and times.

- San Francisco
HIV Health Services Planning Council Meeting

May 27, 2003

**City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place**

May 27, 2003

4:30 PM - 7:30 PM

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DRAFT MINUTES

I. Call to Order

The meeting was called to order at 4:35 p.m.

II. Roll Call

See attachment A.

III. Review and Approval of Agenda

The agenda was amended to include an update on Council support and a report from the Steering Committee, and then it was approved.

IV. Review and Approval of Minutes April 28, 2003

The minutes of the April 28, 2003 meeting were approved.

V. General Announcements

Laura Thomas distributed the 2003 HIV Prevention and Social Services in San Francisco resource guide, produced by the SF DPH AIDS office. The guide was mailed to providers and additional copies can be obtained by calling (415) 554-9000.

Catherine Geanuracos reported back about the recent meeting with the Prevention Planning Council's co-chairs. The Councils will hold a joint (working) meeting on Tuesday, Aug 5, 2003, from 5:00 - 7:30 p.m., location to be determined.

Council members agreed to hold an additional meeting during the summer. The meeting will take place on July 14, 2003 from 4:30-7:30 p.m. and will be held either at City Hall or at Walden House.

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VI. Public Comment

Patrick Monette-Shaw commented: "Laura Thomas from the San Francisco Department of Public Health, just distributed an "HIV Prevention and Social Services in San Francisco" resource guide that was published by the SF DPH's AIDS Office. In response to my direct question about whether this new 232-page, perfect-bound guide is the same resource guide that is distributed by the San Francisco AIDS Foundation, Ms. Thomas said: "No, they are two separate guides." My question is: Does San Francisco – glutted with an inordinate amount of HIV/AIDS funds -- have so many HIV/AIDS resources available at its discretion that we can afford two, slick, and expensive "guides" to various prevention and healthcare services resources in the City, possibly involving duplication of effort? Are there no "economies of scale" parameters in place to issue a single "guide" that directs both providers and consumers to agencies that provide both "prevention" and "healthcare services" in a single 'guide'?"

VIII. Presentation: San Mateo County Update - San Mateo County AIDS Program Staff

John Conley (Director of the San Mateo County Department of Public Health's AIDS Program) presented a summary of the current state of HIV epidemic in San Mateo County. Detailed demographic information was distributed and reviewed. Then information about services, needs and planning was presented.

The AIDS epidemic in Northern and Southern San Mateo county are significantly different. Northern San Mateo county is similar to San Francisco (primarily MSM and Caucasian), and Southern Mateo County is predominately African American and Latino with more than 50% transmission by injection drug use. In broad terms, HIV in Southern San Mateo County is similar to the situation on the East Coast and Northern San Mateo County reflects the current situation in California. San Mateo differs from San Francisco in that it lacks a vocal community and political influence in support of HIV services. It was noted that the beginning of the AIDS epidemic occurred at the same time as high rates of injection drug use in East Palo Alto. Currently African American men account for 5% of the overall population, but they have a disproportionately high percentage of HIV. African American women are approximately ten times more likely to contract HIV than any other group of women in the county because of their partner's drug use, and the high rate of incarceration for African American men. In San Mateo's rural and agricultural population there has been a substantial increase in HIV rates in the Latino community, especially among monolingual Spanish speakers. One of the most significant factors in the county is the lack of rent control, which makes securing stable housing difficult. Currently the county provides subsidies for as long as it takes to get a person into housing that they can afford at their income level, as well as providing help on occasional basis. (Margot Antonetty commented that is information that should be shared with HRSA) Over 60% of the clients served at the primary care clinic identify themselves as heterosexual. San Mateo has a small provider circle. The small size allows for providers to easily communicate with one another and clients are likely to learn about services providers communicate with one another, but the 'one size fits all'

doesn't work well for all clients and situations. A word of caution was noted about the charts and graphs showing information by demographics in the information that was distributed, to comply with HRSA, "Latino" has been replaced by "Of Hispanic Origin", and this makes it more difficult to find information. John Conley also noted that the information he distributed also includes a copy of latest satisfaction survey, which is followed by comments that were recorded verbatim and not verified by any of the departments.

He thanked the people who participated in the Contract monitoring, and stated that all contracts will go out as RFPs this fall.

There was no public comment on this item

VII. Presentation: Reggie Data Demographics, DPH Staff

Steve Solmon (AIDS office database administrator) did a presentation about the demographics and characteristics of the client data from the Reggie system. He reviewed the differences between the data he was going to present and last year's presentation, elaborated on sample size and gave a review and explanation of terms. He noted that gender identification is mostly male, but transgender and female are also specified. He also noted that with the recent HRSA category change (Latino/Hispanic descent) more people identified as white/Caucasian. He stated that there is generally 10-15% missing data on system-wide reports.

Summary of Data

- Housing: The majority of Reggie clients rent or own, this is followed by the number living with friends.
- Age: The majority fall between 40-49 years old. Catherine Geanuracos noted the increasing complex medical needs of this aging population.
- HIV exposure risk: 62% MSM, MSM-IDU 11%
- Income: Currently Reggie asks two questions about income: amount and among how many is it shared, in the future it would be more useful to use the Federal Poverty level for comparison.
- Health Insurance: Majority on MediCal, ¼ have none and ¼ have private insurance
- Primary source of health care: 56 % use CARE funds. Laura Thomas clarified that 2% reported no health care and rely on the emergency room
- Use of Antiretroviral Treatment: Yes 64% No 36%
- Latest CD4 Counts & Viral Loads: Majority under 500/undetectable

Jim Dilley (POH) asked about getting data for CARE funded only; this is not possible at the present time. Questions for the next presentation include: The concentration of services per client (e.g. how many clients accessing one, two etc.), and an overview of the overall services in the city for CARE eligible clients.

Public Comment

Naomi Prochovnick (Program Director, The Tenderloin Collective) asked about including a demographic breakdown by category; Catherine Geanuracos replied that last year's summary sheets will be done again this year. A member of the public asked about using culture instead of race for demographic profiling, Steve Solmon explained that the categories come out of the AIDS Office/HRSA/Health Commission and also noted collecting data become increasing difficult with additional categories.

Patrick Monette-Shaw commented: "A year ago, when this Council "prioritized" HIV/AIDS services in San Francisco, you battled San Francisco's Department of Public Health to prevent CARE Act funds being diverted from primary healthcare services to scrubbing of the Reggie database, which continues to contain faulty data, by using data-scrubbers in "Hazmat" suits to clean up the Reggie database. The presentation we just heard states that a variety of among factors ostensibly being measured by Reggie, several categories continue being tracked inaccurately; "unknown" and "missing" answers are rampant, including "HIV/AIDS Status" (12%), "HIV Exposure Risk" (18%), "Per Capita Household Income" (22%), "Primary Source of Health Care," (16%), "Health Insurance" (14%), "Use of Anti-retrovirals" (22%), "Latest CD4 Counts" (16%), and "Latest Viral Loads," (21%), among others containing incomplete data. San Francisco's receipt of CARE Act funds hinges on accurate data to depict the current HIV/AIDS epidemic. When are you going to dump Reggie?"

IX. Presentation: Marin County Update, Marin County AIDS Program Staff

Alison Clayton (Interim Program Manager for HIV/AIDS Health Services) presented a summary of current state of HIV epidemic in Marin County; she reviewed County's demographics, services and needs. There are ~ 375 living AIDS cases in the County, and of these ~ 150 use the County's primary clinic (these numbers exclude the cases at San Quentin). The demographic breakdown is similar to San Francisco's with approximately 90% male, however the numbers are much smaller with approximately 3.2% of the EMA. The population in Marin County is 79% white and 72% are between 40-59 years old (the added complications of cardiovascular disease were noted). Much like San Mateo County, Marin has seen a rise in the number of cases in the Latino/Hispanic community.

The HIV positive population is composed of mostly gay white men falling in the 40-59 age range, and 66% patients have an income of less than \$900/month; 42% report living alone and 52% share; 68% unemployed; the majority have a combination of public and private insurance. In recent years the number of hospitalization cases has remained fairly stable, but the past five years have seen an increase in triple diagnosis (HIV, mental illness and substance abuse). The County's services—such as mental health—aren't supported by Title 1 funds and are underwritten by the county. Marin, like San Mateo County, has a small number of service providers. They hold

bi-weekly meeting to coordinate services, and because the County lacks a strong advocacy group, actively advocate for their clients.

A recently completed clinic satisfaction survey had a 34% response rate, 83% rated the medical care “excellent” (this is likely due to the bilingual healthcare program), high ratings were also given to office staff, the number of issues addressed at each visit, the ability to get an appointment within a week, time spent in the waiting room averaged less than 30 minutes, and clinics were described as easy or fairly easy to get to.

Housing is a major problem because there is no rent control. The needs assessment conducted last fall reported that 83% stated they were taking anti-HIV medications, 61% reported experiencing some side effects, 80% reported that their service providers had talked with them about HIV prevention and safe sex. When asked to prioritize services, the clients’ top five services in priority order were outpatient medical care, housing, assistance with drug costs, dental care and emergency funds. There’s also unmet dental care need because there’s only one provider in the county.

Kevin Johnson asked if there’s tracking of the number of people who come to San Francisco for services. Alison Clayton replied that the county doesn’t track exact numbers, the majority access primary case services in Marin, and there is referral to the specialized services available in San Francisco.

There was no public comment on this item.

X. By-Law Change - VOTE

The Council voted unanimously to approve the by-law change that will remove references to the People with AIDS Caucus (PWA) and the former Attachment A from the Council's by-laws and policy and procedures. These guidelines will become part of the Membership Committee's policy and procedures document.

Vote called: There was unanimous consensus

There was no public comment on this item

XI. Dinner Break

XII. Presentation- Review of Previous Needs Assessment Data/ Report- Michael deMayo of LaFrance Associates

The Council invited Michael deMayo, LaFrance Associates, to give an overview of the most recent full needs assessment report in preparation for this year's prioritization. Michael deMayo explained that the assessment focused on measuring service needs from different perspectives and identifying gaps in services. After reviewing the information, he recommended that the Council use it to determine gaps in service, why they exist, and who they affect.

The information was gathered in both San Francisco and San Mateo County at Title 1 providers. After receiving training, 25 people living with HIV went into the field to collect data. He cautioned that data is two years old, as it was collect last spring and reflected on the prior year. He also explained there are several ways to rank the data, for example by need or by gaps.

The survey asked the following four questions for all the service categories: Awareness of service, Perception, Demand and Utilization. The data was then measured to determine gaps. When looking at the graphs, the small numbers on the top of some of bars indicated the top ten needs measured in response to the question "Do you need this service?" Shading in the different categories identifies the top ranked needs by gender. Services needed, asked for, and received reveal important gaps. In some cases, clients ranked services differently than how the Council ranked services last years; for example mental health ranked high, but not by the Council. Michael deMayo noted that this poses interesting questions about the Council's interpretation of data and how clients perceive services.

The categories used for this assessment came from the Reggie system and the next one will use categories that match the Council's. Alison Clayton noted that the data showed that more people received medical care than ask

for it, Michael deMayo explained that this because people did not perceive/include regular appointments in answering this category. He also noted that outpatient medical care was the only category where more people received services than asked for them. Food vouchers shows the largest gap because most people didn't know about them and when they received the information they answered 'if I'd known about it I'd have needed it'; this is one of the reasons that it is important to look at information from several perspectives.

The comparison between asked for and received is also graphed. Structural, organizational and individual barriers to services were identified; this data was not tracked by service category.

There was no public comment on this item.

XIII. Review/Approve the planned allocation of FY03-04 Title I grant funds - VOTE

After a brief discussion that confirmed that the total dollar amount was determined as: \$33.9M *Title 1* in addition to \$1.4M *Title 2* with \$1.6M subtracted for Administration. It was noted that it will be important to frequently review the numbers from the AIDS office during the coming year. The motion was put forward Kevin Johnson and seconded by Charles Siron. Alison Clayton abstained from voting, and the rest of the Council voted unanimously to approve the budget.

There was no public comment on this item.

XIV. Update: AIDS Drug Assistance Program, Jeff Byers, California State Office of AIDS

The Governor's original budget proposal for ADAP had a co-pay scale for those earning 201% of the Federal Poverty Level (FPL) and above; the proposed co-pays were \$30/\$45/\$50. In the Governor's newly released May Revise, the new proposed co-pays are \$5/\$10/\$15. The ADAP budget has been discussed in both the Senate and Assembly Committees, and each committee has come up with its own proposed ADAP budget. Neither proposal seems to support co-pays, however both proposals will go to the Conference Committee where differences will be hammered out.

Catherine Geanuracos stated that an ADAP update will be a regular Council meeting agenda item during prioritization.

There was no public comment on this item.

XV. Committee Reports: Steering

Leah Crask has accepted the Council's administrative support position and will begin on June 2, 2003.

Recruitment for the Director of Community Support position continues; so far 10 applications have been received. Shanti will conduct screening interviews, which will be followed by a panel interview. Council members interesting in participating in the interviewing should contact Shanti.

XVI. Committee Reports - Membership

Kevin Johnson reported back about the committee's May 12th meeting. HRSA has been in contact about the lack of Medicaid representation and low Latino representation. Ken Pearce is drafting a letter for Medi-Cal and the State office of AIDS is assisting in finding a representative, and there is active recruitment for Latino members. Brad Hume and Charles Siron have been in contact with members who have not attended meetings in some time. Several people are resigning, including Larry Cruz who is resigning for health reasons. One of the tasks of the membership committee will be to work on recognizing members for their contributions. The roster for the new committees should be finalized by the next Council meeting.

There was no public comment on this item

XVII. Committee Reports – Infrastructure and Policy

Originally named the Implementation, members renamed the committee as Infrastructure & Policy. Charles Siron and Charlene Pugh are the committee's co-chairs. They will examine the workings of the Council, as well as the interaction with the AIDS office. Reviewing the grantee assessment and MOU will take place at their next meeting. The committee needs more members, currently only three people have signed up.

Public comment

The question of members of the public joining committees was raised. Kevin Johnson explained that all meetings are open to the public, but only Council members can vote. He stressed that input from the public helps to move the vote.

XVIII. Committee Reports - Evaluation

Anita Booker and Randy Allgaier are the co-chairs of the Evaluation committee. The committee will look at how the Council makes decisions, compare needs assessments, examine data and collect information from other committees.

There was no public comment on this item

XIX. Committee Reports – Community Action

Donald Frazier and Darnell Durio are the co-chairs of the Community Outreach & Advocacy committee. The meeting was attended with active participation. A mission statement will be finalized in future meetings. This committee sees itself as a potential information gathering and dissemination center; members from other committees hold other Council/Committee/Board seats, and providers were encouraged to attend meetings. The committee identified two primary tasks: Holding a community forum, holding a joint meeting between the Care Council and the Prevention Council.

A community forum will be held in July, in the Bayview Hunters Point district, at Southeast Community College. Cynthia Selmar (African American Health Initiative) will do outreach to providers, Jimmy Loyce (DPH) will be invited to facilitate; Supervisor Sophie Maxwell will also be invited. Council members and members of the public are encourage to attend the next committee meeting on June 10th, it will be an active planning meeting in preparation for the upcoming forum.

As announced by Catherine Geanuracos earlier in the meeting, a joint meeting will be held with the Care Council and Prevention Council on August 5, 2003 from 5:00 – 7:00 p.m. A location for the meeting has not been determined.

The committee hopes to hold community forums each quarter, each in a different section of the city.

Mark Dunlop suggested the formation of a subcommittee to examine the issue of African Americans and HIV.

Randy Allagaier reported back about CAREAR committee; he distributed a memo summarizing the information.

There was no public comment on this item.

XX. Committee Report – Planning

The first meeting of the Planning committee did not accomplish what was hoped in terms of developing a mission statement; the committee's immediate focus is prioritization. Susan Shea and Bill Blum are the co-chairs.

There was no public comment on this item

XXI. Next Agenda

There were no items for the June Council Meeting agenda.

MAY 22 2003

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HIV Health Services Planning Council
5/28/2003 4:30 – 7:30
City Hall Room 201

DRAFT

<u>Item</u>	<u>Presenter</u>	<u>Time</u>
1. Roll Call	Group	4:30
2. Review/Approve Agenda	Group	4:35
3. Review/Approve Minutes	Group	4:40
4. Announcements	Group	4:45
5. Public Comment		4:55
6. Reggie Data/Demographics Presentation		5:05
7. San Mateo County Presentation		5:35
7. Marin County Presentation		5:40
8. Review of Report on ISPs		5:55
9. VOTE – Bylaws Change		6:10
. Dinner		6:15
10. Review of Previous Needs Assessment Data/ Report		6:30
11. Review/Approve the planned allocation of FY03-04 Title I grant funds		6:45
12. ADAP/Jeff Byers		6:55
13. Committee Reports - Membership		7:00
14. Committee Reports – Infrastructure and Policy		7:06
15. Committee Reports - Evaluation		7:12
16. Committee Reports – Community Action		7:18
17. Committee Reports - Planning		7:24
18. Adjourn		7:30

Note: Agenda items are subject to change, postponement, or removal. Meeting agendas are considered to be in DRAFT form until reviewed and approved by Committee attendees.

San Francisco
HIV Health Services Planning Council
Membership Committee

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Membership Bylaws
(Attachment A to Council Bylaws)

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- The Membership Committee will meet monthly to evaluate representation of the membership of the Planning Council, and will ensure that the Council membership meets the requirements of the CARE Act, locally determined criteria concerning representation outlined in the Council's bylaws, as revised on November 23, 1998, and all relevant HRSA guidance concerning membership and the appointment of new members.
- If federally mandated or locally required membership categories are not currently filled, or if the composition of the current membership does not reflect the demographics of the epidemic in the San Francisco EMA, the Committee will identify the areas of needed representation and will prepare to recommend individuals for appointment to correct this lack of representation.
- As part of its evaluation process, the Membership Committee may prioritize specific membership vacancies, and emphasize the need to obtain particular areas of knowledge, expertise, or representation.
- The Committee shall conduct regular, not less than quarterly, targeted recruitment including, but not limited to, public notices in the press to notify the community that vacancies exist in specific membership categories and areas of representation, and that nominations for membership may be submitted.
- Advertisements requesting nominations for specific categories of membership, or areas of representation will be placed in newspapers of record in the EMA, including papers serving the lesbian/gay/bi/transgender community, and other papers serving the particular communities from whom individuals are being recruited. Such advertisements shall include a description of the Council's attendance and conflict of interest standards, term of office and HIV disclosure guidelines.
- All nominations for membership will be submitted in writing to the Membership Committee, and should follow the format contained in the Membership Nomination Form (attached).
- The Membership Committee shall review all Membership Nomination Forms in consideration of the Council bylaws requirements concerning representation, and will recommend to the Planning Council at its next meeting those applicants, which most effectively fill the vacant areas of representation.

- The bylaws requirements concerning mandated areas of representation, as well as the composition of the Council membership, and the extent to which it reflects the demographics of the epidemic within the EMA, will always be taken into consideration in evaluating nominations. In addition, the Membership Committee shall take into account the Council's conflict of interest standard, as well as relevant guidance from HRSA regarding membership and conflict of interest.
- The Planning Council will review the recommendations of the Membership Committee, and will vote to accept or reject the Committee's recommendation. If the Council votes to accept the Membership Committee's recommendation, the Membership Co-chairs will submit the recommended nominees to the Mayor for consideration. If the Council rejects the Membership Committee's recommendation, it must state a clearly articulated justification for doing so. The Membership Committee will then reconsider its recommendation at its next meeting, and forward a recommendation to the Council at the next Council meeting.
- Following a review and consideration of the Council's recommendation, the Mayor may appoint new members to the Planning Council from among those individuals recommended by the Council. In accordance with HRSA guidance regarding the appointment of new members, if the Mayor chooses not to appoint individuals to vacant Council seats, a clearly articulated justification must be submitted to the Membership Co-chairs along with any communication concerning the choice not to make appointments to vacant seats.
- In accordance with the CARE Act, reimbursements shall be made available to HIV+ members to facilitate their participation in Council meetings. These reimbursements may be used for transportation, childcare, food, and wages lost as a result of attending Council meetings. Valid documentation must accompany bill.
- Appointments for those members representing specific agencies are only for as long as such individuals are employed by such agencies.
- In accordance with the bylaws as adopted by the Council on November 26, 1998, concerning terms of office, the term of office shall be two years. Individuals may submit an application to serve a subsequent term to the Membership Committee in advance of the end of their current two-year term.
- Individuals appointed before November 26, 1998, shall serve the balance of a term determined by the month and year of their original appointment. Terms for members appointed in an odd year shall end in 1999, while terms for members appointed in an even year shall end in 2000. Those individuals seeking appointment to a subsequent term shall submit an application for consideration at the Membership Committee meeting at least two months prior to the end of their term, in order to allow time for the Membership Committee to consider their application and forward recommendations to the Council at the Council meeting of the month prior to the end of that member's term. Members seeking to be appointed to subsequent terms shall

be encouraged to submit applications early, in order to avoid gaps in membership. For example, an individual appointed in September 1995 will be currently serving a term, which will end in September 1999. This individual, should they wish to seek appointment to a subsequent term, shall submit a nomination application to the Membership Committee no later than the Membership Committee meeting of July, 1999, in order to be considered for recommendation to the Planning Council at its August meeting, and will be subject to the process as outlined above.

- The Membership Committee shall be responsible for maintaining a record of appointment dates of Council members, and for notifying members of the dates of the end of their terms. The Membership Committee shall notify members of the date of the end of their term at least three months in advance, in order to allow members interested in submitting Membership Nomination Forms ample time to do so and to be considered by the Membership Committee, the Council, and the Mayor in time to be appointed to a subsequent term before the end of their current term.
- The Membership Committee shall be responsible for ensuring that the Process for the Nomination and Appointment of New Members, as outlined above, is consistent with the Council's Bylaws, and shall make revisions, and notify the Council and the Mayor of any revisions made to this Process.

Policies & Procedures

MISSION STATEMENT

The mission of the Membership Committee of the San Francisco HIV Health Services Planning Council is to recruit, train and retain members.

TRACKING ATTENDANCE

Council support staff will conduct a quarterly report to assess whether Council members are meeting the minimum attendance requirements, as outlined in the bylaws.

COMMITTEE ASSIGNMENTS

In an effort to diversify levels of understanding, interest and participation in Council work, committee seats will be assigned and limited to ten (10) members per committee. At least one Co Chair will be HIV Positive.

For the first three months of a Council member's term, s/he is required to attend at least one committee per month (as stated in the bylaws). After the first three months, the Council member will provide the Membership Committee with their top three priorities for which committee they will commit to on a regular basis. Membership Committee will then assign the new member to the committee with an open seat, or one that would maximize their strengths and abilities.

Council members may only sign up for a committee that has an open seat. Thereafter, all Council members are expected to attend their home committee on a regular basis. Attendance at committees other than a Council member's home committee will be noted

on all attendance reports, but will not count towards that Council member's attendance requirements. Any Council members who do not attend their home committee will be noted in the minutes as "absent". Committee co-chairs shall contact members who are absent from their home committee regarding their absence.

ABSENCES

As stated in the bylaws, The minimum attendance required is five meetings in a quarter, including at least two full Council meetings and three Committee or Task Force meetings, or other official Council activities. If there are fewer than three full Council meetings in a quarter, the minimum expectation for the number of full Council meetings will reduce attendance canceled. Council members are responsible to inform staff when they are unable to attend their designated committee, or the full Council meeting.

In consideration of the need for representation of persons with HIV, those individuals shall be exempt from the bylaws' termination clause for absences due to illness.

Occasional meetings, such as Community Forums, temporary Task Force committees, can be attended to fulfill attendance requirements that were not met due to unexcused absences.

LEAVE OF ABSENCE

A leave of absence is requested by written notice to the Council support staff or Membership Committee. As stated in the bylaws, a leave of absence may not exceed two (2) months. Persons not returning by the end of the two (2) month period will be considered to have resigned. Leaves of absence are granted only for reasons of work or personal or family health. The number of members required to establish a quorum shall be adjusted to exclude members on authorized leaves of absence. Individuals are encouraged to consider the adequate representation of their constituency when deciding between a leave of absence and resignation.

TRAINING/ORIENTATION

When specific training needs are identified, trainings will be conducted accordingly. Membership Committee will conduct trainings on a regular basis at times that member recruitment and screening are not required

Within 60 days of appointment, all Council members are required to attend an orientation.

ATTENDANCE

A member in good standing fulfills attendance requirements, as stated in the bylaws. S/he would:

- regularly communicate with staff regarding absences;
- Attend orientation within 60 days of appointment; and
- receive ongoing core competency training as overseen by the Membership Committee.

A member may be placed on probation if any of the following occur:

- Attendance falls below minimum requirements within one quarter;
- Has not attended orientation within the 1st year of appointment; or
- Does not respond to requests made by the Council staff or Membership Committee.

A member may be considered for resignation from Council membership if:

- The Membership Committee determines them unfit for continued membership based on ongoing probationary status;
- Absences exceed quarterly allowance and member does not communicate with Council staff or Membership Committee when requested to do so.

Members will be informed that they are placed on probation by written correspondence, as instructed by the Membership Committee during the quarterly attendance review. The member will be asked to respond with their circumstances and their disposition will be reviewed at the following Membership Committee meeting. If the member does not respond, a second letter will be sent asking for another response. If the member does not respond to the second request, the Membership Committee will assume their resignation.

REVIEW OF APPLICATIONS & INTERVIEW PROCEEDINGS

Applicants to the HIV Health Services Planning Council are required to complete an application form and attend at least one full Council meeting. The Membership Committee will review applications and conduct interviews at times specified in the calendar (see attached). Interviews will consist of meetings with individual applicants. A copy of the suggested interview questions is attached.

RESIDENCE OF PLANNING COUNCIL MEMBERS

The principal residence of Title I planning council members who represent affected communities, people with HIV, non-elected community leaders, or historically underserved groups and subpopulations must be within the geographic boundaries of the EMA for the length of the term in which they are serving on the council. In cases where a Title I planning council also serve as a Title II regional consortium and the consortium boundaries are larger than those of the EMA, residency requirements shall apply to the larger boundaries.

The principal residence of individuals filling legislatively mandated organizational seats on Title I planning councils (health care providers, including federally qualified health centers; community-based organizations serving affected populations and AIDS service organizations; social service providers; mental health and substance abuse providers; local public health agencies; hospital or health care planning agencies; State government, including the Medicaid agency and Title II administering agency; other CARE Act grantees; and other Federal HIV programs) should be within the geographic boundaries of the EMA, but this is not required. It is recognized that this **may not** be possible for individuals representing the Title II administering agency and/or the State Medicaid agency. To qualify for organizational representation on a planning council, entities of the types named above must provide services within the boundaries of the EMA.

San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

**PACKET FOR DEVELOPMENT OF
MEMORANDUM OF UNDERSTANDING (MOU)
BETWEEN PLANNING COUNCIL AND DPH/GRANTEE**

TABLE OF CONTENTS

TAB 1:

**Recommendations for Inclusion in Memorandum Of Understanding
(MOU) Between Planning Council and DPH/Grantee**

TAB 2:

**Documents Prepared for Grantee Assessment Task Force Relevant to
MOU**

TAB 3:

**Instructions and Templates from CAEAR Coalition Foundation
Training and Sample MOUs from Other EMAs**

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San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

RECOMMENDATIONS FOR INCLUSION IN MEMORANDUM OF UNDERSTANDING (MOU) BETWEEN PLANNING COUNCIL AND DPH/GRANTEE

Recommended First Steps:

I recommend that early in the process of agreeing on the MOU, you ask HHS representatives to review the following documents (prepared for the Grantee Assessment Task Force and included in this packet) and revise according to actual dates and feasibility:

- Recommendations for Assessment Process and Timeline
- Recommended Documentation
- Proposed Timeline/Tracking Report
- Measurement and Assessment Findings Table

Examples from other EMAs and Templates:

I contacted several EMAs (Chicago, Alameda, Boston, Santa Clara County, Dutchess County NY) and several people who work with other EMAs, and very few have MOUs in place, though several said they hope to develop one in the near future.

Copies of the following have been provided to the Planning Council Co-Chairs and lead staff and the HHS staff person who is preparing a draft MOU for consideration:

- *MOU Basics* and blank *MOU Template* (from CAEAR Coalition Foundation Opening Doors Training held in December 2002). The specifics are not very relevant since the focus is more on MOUs between service providers, but the general format and categories may be useful
- *Cooperative Agreement between the Seattle-King County Department of Public Health and the Seattle HIV/AIDS Planning Council*, with potentially useful attachments, *Roles and Responsibilities* and *Conflict Resolution Model*. This agreement covers a broad range of issues, however, it is primarily focused on staffing, roles, and responsibilities. The *Conflict Resolution Model* seems to be well-conceived and could be useful for San Francisco.
- *HIV Health and Human Services Planning Council of New York Memorandum of Understanding: Planning Council Evaluation of the Administrative Mechanism*. This MOU is very specific to the grantee assessment process, incorporating reporting requirements, timelines, and other related issues.

Grantee Assessment-related:
Roles and responsibilities (#6, continued)

- ❑ Council monitors and conducts assessment of Grantee with respect to "whether the Grantee is efficiently and rapidly disbursing funds to the areas of greatest need."
- ❑ Grantee reports to Council (see *Recommended Documentation* in Assessment Templates Packet)
- ❑ Grantee provides to Council copies of documents and reports submitted to HRSA

7. Assessment Process

- ❑ Council committee and staffing for conducting the assessment
- ❑ Grantee commitment to standards and process developed by GATF, to report and provide copies as indicated in *Recommended Documentation* and *Timeline/Tracking Report* in Assessment Templates Packet, and to complete annual self-assessment and work with GA Committee on action plan for coming year.
- ❑ Timeline for conducting assessment

8. Timelines

- a. Grantee reporting pursuant to Assessment Templates Packet
- b. Timelines for Grantee contract development, certification, and monitoring
- c. Contractor reimbursement timelines
- d. Timelines for Council decision-making, prioritization process, and other responsibilities required by the CARE Act or HRSA

MEASUREMENT AND ASSESSMENT FINDINGS TABLE

GSA = Grantee Self Assessment	PC = Planning Council Survey	Prov = Provider Survey
TT = Timeline/Tracking Report	GA Comm = Council committee working on grantee assessment	

CATEGORY 1:

Services procured in accordance with priorities established by the planning council

Standards	Regular Mechanism for Measurement	Who has this info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
a. Appropriate providers for each priority area are targeted and provided notice regarding the availability of funds	DPH sends solicitation list and copy of solicitation packet after each CARE-related solicitation.	Contracts	GSA Prov PC		
b. Funds distributed to communities funded by the Ryan White CARE Act according to priorities and allocations as determined by the Council	DPH sends list of award letters after letters for each CARE-related solicitation. DPH sends copy of Table 10 after it is sent to HRSA.	Contracts	GSA Prov PC		

CATEGORY 2:

Fair and effective solicitation process

Standards	Regular Mechanism for Measurement	Who has this info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
a. Solicitation process consists of standardized steps and format across all potential applicants	DPH provides copy of solicitation process policies and procedures. Solicitation packet (see 1a).	Contracts	GSA Prov		
b. All requirements for HRSA are included in the solicitation and discussed, when applicable, at the Bidders Conference	Solicitation packet (see 1a). DPH sends bidders conference minutes after each CARE-related solicitation.	Contracts	GSA Prov		
c. Support for prospective subcontractors for responding to a solicitation (e.g., training workshops, resource materials)	DPH sends list of TA offered and topics covered as part of quarterly report.	Contracts	GSA Prov TT		

CATEGORY 2, continued:
Fair and effective solicitation process

Standards	Regular Mechanism for Measurement	Who has this Info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
d. Sufficient time provided to insure a fair and competitive process for the submission of bids by all interested applicants	Solicitation packet (see 1a).	Contracts	GSA Prov		

CATEGORY 3:
Efficient and effective funding awards

Standards	Regular Mechanism for Measurement	Who has this Info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
a. Awards made in accordance with established criteria	DPH provides list of criteria used for solicitation or renewal.	AIDS Office	GSA Prov		
b. Awards made in adherence to published schedule for making awards and completing contracts	DPH sends schedule as part of annual report.	AIDS Office	GSA Prov TT		
c. All new and renewal contracts certified by start date of services (tracked on quarterly basis by service category)	DPH reports monthly on # and % of contracts certified and funded.	AIDS Office	GSA Prov TT		
d. All funds allocated by end of the award process	DPH reports quarterly on solicitations, and status of allocated funds. DPH sends copy of FSR	AIDS Office	GSA PC TT GA Comm spot checks solicitations for % of allocated funds		
e. Adherence to Planning Council's Unfunds Policy	DPH reports monthly on amount of \$ unallocated and unobligated, and how these are being addressed.	AIDS Office	GSA PC TT		

CATEGORY 3, continued:
Efficient and effective funding awards

Standards	Regular Mechanism for Measurement	Who has this info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
f. Prompt communication with subcontractors re: fiscal developments that impact funding	DPH adds PC staff to subcontractor mailing list (to receive all correspondence subcontractors receive)	AIDS Office	GSA Prov		

CATEGORY 4:
Effective subcontractor relationships

Standards	Regular Mechanism for Measurement	Who has this info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
a. Communication: Prompt (within 5 working days) responses to verbal or written requests for information and/or assistance from: • Subcontractors • Planning Council staff, • Council Co-chairs • Council Committee Chairs			GSA Prov PC		
b. Technical assistance provided to subcontractors by grantee as needed (including for contract negotiations)	DPH reports quarterly on TA provided - # trainings held, topics covered, # and types of individual TA provided	AIDS Office	GSA Prov TT		
c. Timely processing (within 2 weeks) of complete and accurate invoices			GSA Prov		
d. Effective fiscal monitoring: Monitor subcontractor spending (to avoid over-or under-spending)	DPH reports monthly on status of monitoring efforts	AIDS Office	GSA Prov TT		

CATEGORY 4, continued:
Effective subcontractor relationships
Standards

	Regular Mechanism for Measurement	Who has this Info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
e. Effective program monitoring: Development of and adherence to monitoring policies, e.g.,	DPH provides copy of monitoring policies and procedures	AIDS Office	GSA Prov		
• Monitoring teams w/o conflicts of interest					
• Standard procedures for determining other payors for services					
f. Effective program monitoring: Subcontractors receive adequate notice of monitoring process and criteria			GSA Prov		
g. Effective program monitoring: Grantee regularly assesses effectiveness of program monitoring and improves as appropriate	DPH reports monthly on status of contract monitoring (w/o specific identifying information on individual subcontractors)		GSA Prov TT		
h. Effective program monitoring: Monitoring report completed and returned to subcontractor within two months of submission of the protocol	Monthly reporting (see 4g)		GSA Prov TT		
i. Effective program monitoring: Formal system for consumers to be part of monitoring teams	DPH provides copy of plan for involving consumers in monitoring teams		GSA Prov PC		

CATEGORY 5:

Comply with tracking and reporting systems established by the MOU

Standards	Regular Measurement	Who has this info?	Annual Mechanism for Measurement	Numerical Rating (for annual assessment)	Findings (for annual assessment summary)
a. Reports submitted in accordance with agreed-upon timeline	Timeline/tracking report completed on monthly basis by GA Committee		TT GSA PC		
b. Reports provide agreed-upon information including explanation of barriers experienced in meeting standards	Timeline/tracking report completed on monthly basis by GA Committee		TT GSA PC		

San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

RECOMMENDED DOCUMENTATION

Information for Grantee to Provide to the Planning Council

(based on HRSA recommendations, other EMAs practices, and mechanisms for measurement discussed by the GATF)

Initial documentation/actions:

(should also send updated copies when revised)

- a. Copy of solicitation process policies and procedures
- b. Copy of program monitoring policies and procedures
- c. Copy of plan for involving consumers in monitoring teams
- d. Add PC support staff to subcontractor mailing list (to receive all correspondence subcontractors receive)

Grantee monthly report (presented verbally to Steering Committee or full Planning Council), including:

- a. Status of solicitations, criteria for determining whether to issue solicitation
- b. Status of contract monitoring (w/o specific identifying information on individual subcontractors)
- c. Number and percent of contracts certified and funded
- d. Amount of funds unallocated and un-obligated, and plans for how the situation is being addressed
- e. Status of monitoring contractor spending (to avoid over-or under- spending)
- f. Status of proceedings, finalization, and implementation of City and County of San Francisco Non-Profit Contracting Task Force recommendations
- g. Problems and barriers encountered

Grantee quarterly report (written), including:

- a. Technical Assistance (TA) provided: number of training workshops held, topics covered, number and types of individual TA provided
- b. Status of solicitations and allocated funds, spending to date by service category
- c. Status of contract negotiations
- d. Summary of subcontractors' mid-year or final reports
- e. Creation and accomplishments of work groups related to Grantee's policies and procedures, standards of care, and input into Grantee activities
- f. Status of reimbursements and explanation of delays

Copy of Grantee reports and documents provided annually

(timing should be determined by the Grantee, based on document availability; dates from HRSA listed in () may not apply for SF EMA)

- a. Table 10
- b. Schedule for making awards and completing contracts
- c. FSR and Annual Report submitted to HRSA (due to HRSA June 1 – 90 days after FY ends)
- d. Minority AIDS Initiative (MAI) mid-year and final Progress Reports (to HRSA Oct. 1 and May 31, respectively)
- e. Planned Allocations for Current Fiscal Year (to HRSA June 14)
- f. Budget indicating amount of dollars for prioritized categories of service (budget on SF 424A to HRSA 45 days after Notice of Grant Award [NGA])
- g. List of providers by prioritized categories of service (date?)
- h. Standards of care for each service category (date?)
- i. Close-out information for previous year, e.g., # of contracts rolling over (date?)
- j. Final year-end program monitoring report (date?)
- k. General summary of audit findings (w/o identifying information on particular contracts) (date?)

As appropriate (timing situational):

- a. After each CARE-related funding award solicitation:
 - copy of solicitation list
 - copy of solicitation packet
 - list of award letters after letters sent
 - bidders conference minutes
- b. List of criteria used to determine whether to issue RFP, solicitation or renewal

San Francisco HIV Health Services Planning Council
Assessment of the Administrative Mechanism

TIMELINE/TRACKING REPORT

*To be completed throughout the year by the Planning Council Committee working on assessment
Copies of reports submitted to HRSA to go to Planning Council within one month after HRSA submission.*

MONTH	ITEM	ON TIME	NOT ON TIME	COMMENTS (e.g., N/A, report complete or incomplete, problems, follow-up)
May 2003				
	Monthly report (oral)			
	Title I Final Allocations for previous fiscal year (May 31)			
	Final Minority AIDS Initiative Progress Report to HRSA (May 31)			
	Initial documents/actions: a. Copy of solicitation process policies and procedures b. Copy of program monitoring policies and procedures c. Copy of plan for involving consumers in monitoring teams d. Add PC staff to subcontractor mailing list (to receive all correspondence subcontractors receive)			
June 2003				
	Monthly oral report			
	Budget indicating amount of dollars for prioritized categories of service (budget on SF 424A to HRSA 45 days after Notice of Grant Award [NGA])			

July 2003	Monthly oral report				
	Quarterly report (3/1-5/31)				
	Final HRSA Financial Status Report (FSR on SF 269) (June 1)				
	Minority AIDS Initiative (MAI) and final Progress Reports (to HRSA May 31)				
	Planned Allocations for Current Fiscal Year (to HRSA June 14)				
August 2003					
	Monthly oral report				
September 2003					
	Monthly oral report				
October 2003					
	Monthly oral report				
	Quarterly report (6/1-8/31)				
November 2003					
	Monthly oral report				
	Minority AIDS Initiative (MAI) mid-year report (to HRSA in Oct.)				
December 2003					
	Monthly oral report				
January 2004					
	Monthly oral report				
	Quarterly report (9/1-11/30)				

February 2004				
Monthly oral report				
March 2004				
Monthly oral report				
April 2004				
Monthly oral report				
Quarterly report (12/1-2/28)				
Yearly <i>(timing should be determined by the Grantee, based on document availability; dates from HRSA listed in () may not apply for SF/EMA)</i>				
Table 10 (date?)				
Schedule for making awards and completing contracts (date?)				
Final year-end program monitoring report (date?)				
List of providers by prioritized categories of service (date?)				
Standards of care for each service category (date?)				
Close-out information for previous year, e.g., # of contracts rolling over (date?)				
General summary of audit findings (w/o identifying information on particular contracts) (date?)				

Ongoing <i>(timing depends on situation)</i>												
After each CARE-related funding award solicitation: • copy of solicitation list • copy of solicitation packet • list of award letters after letters sent • bidders conference minutes List of criteria used to determine whether to issue RFP, solicitation or renewal												
Updates to: - Copy of solicitation process policies and procedures - Copy of program monitoring policies and procedures - Copy of plan for involving consumers in monitoring teams												

San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

RECOMMENDATIONS FOR ASSESSMENT PROCESS AND TIMELINE

General Recommendations

- A specific committee should be charged with ongoing oversight of the assessment process, reporting to the Steering Committee and full Planning Council regularly so Council leadership and all Council members are aware of and engaged in the process. (*This and attached documents and templates refer to this committee as the "GA Committee"*)
 - The standards should be reviewed annually and updated or revised as needed. The ideal time for the GA Committee to review and revise the standards is at the beginning of an "assessment year," i.e., immediately after an annual assessment has been completed and submitted to HRSA. This will insure that the Grantee and Planning Council are aware of the standards to be used for assessment during the subsequent year. If the standards are changed, make the revisions to the master document, *Categories and Standards*. For the annual assessment, it will be important to also revise the parallel wording in all template documents, i.e.:
 - *Measurement and Assessment Findings Table*
 - *Grantee Self-Assessment Instrument*
 - *Provider Survey Instrument*
 - *Planning Council Survey Instrument*
-

Two-Part Assessment Process:

(see specific recommendations for each part, next page)

1. **Regular Ongoing Measurement:**
GA Committee regularly and actively monitors communications, reports, and documents agreed to in the MOU for ongoing measurement of standards (see *Timeline/Tracking Report, Measurement Table, and Recommended Documentation*)
 2. **Annual Assessment/Report to HRSA**
GA Committee conducts assessment annually; develops an action plan and monitoring process in conjunction with the Grantee for standards that are out of compliance so that progress can be tracked and barriers addressed; and reports to HRSA.
-

Part 1. Regular Ongoing Measurement

- Planning Council staff should receive reports and documents from Grantee, and disseminate to the committee charged with grantee assessment to review, determine any follow up needed, and complete the Timeline/Tracking Report. It is best to raise problems with the quantity or quality of reporting as they arise, rather than waiting until the annual assessment is conducted.
- Council support staff should also maintain electronic and hard files submitted by the Grantee for review at the time of annual assessment

Part 2. Annual Assessment/Report to HRSA

Assessment of Grantee's performance should be conducted utilizing the Grantee Self-Assessment, Planning Council Survey, Provider Survey, and the GA Committee's review of the Timeline/Tracking Report and documents provided by the Grantee during the preceding months/year.

- *Quantitative Analysis: scoring process for each standard, e.g., 0 to 5 (outcome not addressed to outcome met and exceeded)*
- *Qualitative Analysis: brief narrative for each category indicating: strengths; weaknesses; external factors; process measures with respect to efficiency, fairness, thoroughness; comments/recommendations for improvement*

Process/Timeline

- **Plan, ideally, 3 months to complete the assessment.**

1 week:

- GA Committee confirms the process, reviews and finalizes instruments and other forms, and plans for implementing the assessment.

3 weeks:

- Ask the Grantee to complete the self-assessment first. (3 weeks turn-around)
- Send out the Provider and Planning Council Surveys (3 weeks turn-around)
 - Set up an internal tracking/numbering system, to insure each agency submits only one survey and to follow up as possible to insure a good response rate.
 - The letter in () at the end of each survey question (for providers and Planning Council members) corresponds with standards list and measurement table. The letter is at the end so as not to confuse respondents since not all standards are included in the surveys.
 - The surveys should be disseminated with a 3-week deadline. Send reminders by phone, e-mail, or mail 2 weeks into the period. Consider having Planning Council members complete their surveys at a regular Council meeting, and mailing to those who are not present.

3 weeks:

- Summarize the quantitative and qualitative findings from the completed Provider and Planning Council Surveys, Grantee Self-Assessment, Timeline/Tracking Report, and documents submitted by the Grantee throughout the year and for the Self-Assessment. You can utilize the Measurement and Assessment Findings Table or establish another document to summarize numerical ratings and findings.
- Begin working with the Grantee to finalize an action plan for the coming year based on the assessment.

4 weeks:

- Forward the draft report to the Grantee for review and comment (2 weeks turn-around); reconvene the Committee to review the Grantee's feedback; revise as needed prior to forwarding to the Planning Council.
- Present to the Planning Council to review and approve.

1 week:

- Finalize the Grantee action plan for the coming year.
- Finalize the report for HRSA (see below).

Staffing for Conducting the Assessment

It is important to know well in advance who will be responsible for assessment tasks, i.e., support staff, volunteer Council members, or consultant (s), so time is carved out for the work.

- Alameda County: conducted as part of support staff contract for Council
- Chicago: contracted with AETC
- Sacramento: contracted with a consultant, Council staff utilized only for logistical support
- Santa Clara County: conducted by support staff for Council

The process and templates recommended for San Francisco are more complicated than those utilized by Santa Clara and Alameda Counties, however, they are not as complex as Sacramento's. The San Francisco process will be fairly intensive, especially during the final 6 weeks of summarizing results for the Planning Council, working with the Grantee to write the action plan, and writing the report to HRSA.

Report to HRSA

The report should be a summary comprised of the following:

- List of the categories and standards used to guide the assessment, indicating that these were adapted from the HRSA sample questions.
- Description of the process followed during the previous months/year and for conducting the annual assessment (indicate the ways that the process follows the HRSA recommendations).
- The process for the future, e.g., a plan for improvements was developed and will be monitored on a quarterly basis during the coming year; that the assessment process will be modified to correct any problems that arose.

- It is best not to go into a great deal of detail about specific problems with the Grantee that came to light during the assessment. Instead focus on the process, that feedback was provided to and from the Grantee, and that an action plan for improvement was (or will be) completed based upon the assessment.

Attachments:

- **Templates used for ongoing measurement**
 - **Timeline/Tracking Report**
 - **Measurement Table**
- **Instruments used for annual assessment**
 - **Grantee Self-Assessment**
 - **Provider Survey**
 - **Planning Council Survey**
- **Quarterly Monitoring Tool**

San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

CATEGORIES AND STANDARDS FOR ASSESSMENT

(agreed upon by the Grantee Assessment Task Force, March, 2003)

Key question to be answered by assessment:

DID THE GRANTEE EFFICIENTLY AND RAPIDLY DISBURSE FUNDS TO THE AREAS OF GREATEST NEED?

Categories for Assessment:

(based on HRSA guidance)

- 1. Services procured in accordance with priorities established by the planning council**
- 2. Fair and effective solicitation process**
- 3. Efficient and effective funding awards**
- 4. Effective subcontractor relationships**
- 5. Comply with tracking and reporting systems established by the MOU**

Standards for Each Category:

- 1. Services procured in accordance with priorities established by the planning council**

STANDARDS:

- a. Appropriate providers for each priority area are targeted and provided notice regarding the availability of funds
- b. Funds distributed to communities funded by Ryan White according to priorities and allocations as determined by the Council

- 2. Fair and effective solicitation process**

STANDARDS:

- a. Solicitation process consists of standardized steps and format across all potential applicants
- b. All requirements for HRSA are included in the solicitation and discussed, when applicable, at the Bidders Conference
- c. Support for prospective subcontractors for responding to a solicitation (e.g., training workshops, resource materials)
- d. Sufficient time provided to insure a fair and competitive process for the submission of bids by all interested applicants

3. Efficient and effective funding awards

STANDARDS:

- a. Awards made in accordance with established criteria
- b. Awards made in adherence to a published schedule for making awards and completing contracts
- c. All new and renewal contracts certified by start date of services (tracked quarterly by service category)
- d. All funds allocated by end of the award process
- e. Adherence to Planning Council's Unfunds Policy
- f. Prompt communication with subcontractors re: fiscal developments that impact funding

4. Effective subcontractor relationships

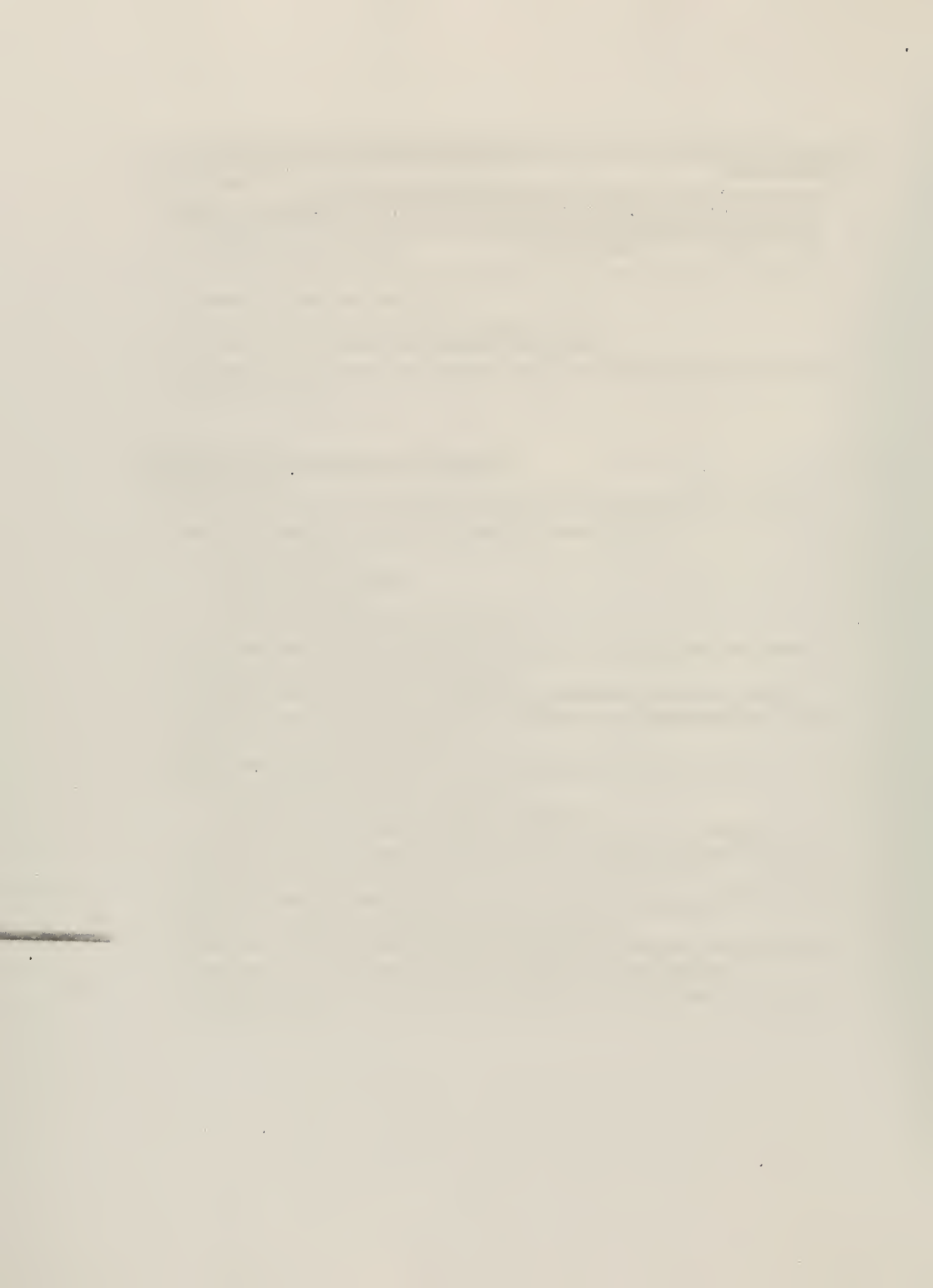
STANDARDS:

- a. Communication: Prompt (within 5 working days) responses to verbal or written requests for information and/or assistance from:
 - Subcontractors
 - Planning Council staff,
 - Council Co-chairs
 - Council Committee Chairpersons
- b. Technical assistance provided to subcontractors by grantee as needed (including for contract negotiations)
- c. Timely processing (within 2 weeks) of complete and accurate invoices
- d. Effective fiscal monitoring: Plan for monitoring subcontractor spending (to avoid over-or under-spending)
- e. Effective program monitoring: Development of and adherence to monitoring policies, e.g.,
 - Monitoring teams w/o conflicts of interest;
 - Standard procedures for determining other payors for services
- f. Effective program monitoring: Subcontractors receive adequate notice of monitoring process and criteria
- g. Effective program monitoring: Grantee regularly assesses effectiveness of program monitoring and improves as appropriate
- h. Effective program monitoring: Monitoring report completed and returned to subcontractor within two months of submission of the protocol
- i. Effective program monitoring: Formal system for consumers to be part of monitoring teams

5. Comply with tracking and reporting systems established by the MOU

STANDARDS:

- a. Reports submitted in accordance with agreed-upon timeline
- b. Reports provide agreed-upon information including explanation of barriers experienced in meeting standards



San Francisco HIV Health Services Planning Council

Assessment of the Administrative Mechanism

Grantee Self-Assessment

The San Francisco HIV Health Services Planning Council is conducting an assessment of the administrative mechanism for Ryan White CARE Act funding in the San Francisco EMA. The CARE Act requires that an annual administrative assessment be conducted by each EMA, to assess:

Whether the grantee efficiently and rapidly disbursed funds to the areas of greatest need.

As a first step in this process, the Planning Council asks the appropriate representatives of the SF DPH to complete this self-assessment. This process will involve many other components including a survey of subcontractors/providers and planning council members to assess the performance of the San Francisco Department of Public Health (SF DPH) as Title I grantee.

The Grantee Assessment Task Force of the Planning Council agreed upon the standards listed below. Please circle the number that most closely reflects how SF DPH performed in each area, with a "5" representing "met and exceeded standard," and a "1" meaning "standard not met." Please use the comments section to explain your ratings and to provide information on barriers experienced and ideas for the future. Comments also can be used to indicate those aspects that are functioning particularly well.

1. Services procured in accordance with priorities established by the planning council CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
a. Appropriate providers for each priority area are targeted and provided notice regarding the availability of funds	5	4	3	2	1	

(1) Services procured in accordance with priorities established by the planning council. *continued*

CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
b. Funds distributed to communities funded by the CARE Act according to priorities and allocations determined by the Council	5	4	3	2	1	

**2. Fair and effective solicitation process
CIRCLE ONE RATING (1-5) FOR EACH STANDARD**

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ SUGGESTIONS FOR IMPROVEMENT
a. Solicitation process consists of standardized steps and format across all potential applicants	5	4	3	2	1	
b. All requirements for HRSA are included in the solicitation and discussed, when applicable, at the Bidders Conference	5	4	3	2	1	
c. Support for prospective subcontractors for responding to a solicitation (e.g., training workshops, resource materials)	5	4	3	2	1	

(2) Fair and effective solicitation process. continued

CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
d. Sufficient time provided to insure a fair and competitive process for the submission of bids by all interested applicants	5	4	3	2	1	

3. Efficient and effective funding awards
CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
a. Awards made in accordance with established criteria	5	4	3	2	1	
b. Awards made in adherence to a published schedule for making awards and completing contracts	5	4	3	2	1	
c. All new and renewal contracts certified by start date of services (tracked quarterly by service category)	5	4	3	2	1	
d. DPH communicates promptly about fiscal developments that impact funding	5	4	3	2	1	

4. Effective relationships with subcontractors
CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
a. Communication: Prompt (within 5 working days) responses to verbal or written requests for information and/or assistance from: • Subcontractors • Planning Council staff • Council Co-chairs • Council Committee Chairpersons	5	4	3	2	1	
b. Technical assistance provided to subcontractors by grantee as needed (including for contract negotiations)	5	4	3	2	1	
c. Timely processing (within 2 weeks) of complete and accurate invoices	5	4	3	2	1	
d. Effective fiscal monitoring: Plan for monitoring subcontractor spending (to avoid over- or under-spending)	5	4	3	2	1	

(4) Effective relationships with contractors (Title I provider agencies) *continued*
CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
e. Effective program monitoring: Development and adherence to monitoring policies (e.g., monitoring teams without conflicts of interest; standard procedures for determining other payors for services)	5	4	3	2	1	
f. Subcontractors receive adequate notice of monitoring process and criteria	5	4	3	2	1	
g. Grantee regularly assesses effectiveness of program monitoring process and improves as appropriate	5	4	3	2	1	
h. Monitoring reports completed and returned to subcontractors within two months of the submission of the protocol	5	4	3	2	1	
i. Formal system for consumers to be part of program monitoring teams	5	4	3	2	1	

5. Comply with tracking and reporting systems established by the MOU
CIRCLE ONE RATING (1-5) FOR EACH STANDARD

STANDARD	Met and Exceeded	Met Above Minimum	Met at Minimum	Partially Met	Not Met	COMMENTS STRENGTHS/WEAKNESSES/ BARRIERS/IDEAS FOR FUTURE
a. Reports submitted in accordance with agreed-upon timeline	5	4	3	2	1	
b. Reports provide agreed-upon information including explanation of barriers experienced in meeting standards	5	4	3	2	1	

Additional Questions:

1. What are the strengths of DPH in managing the Ryan White CARE Act grant?
2. What are the weaknesses of DPH in managing the Ryan White CARE Act grant?

3. What barriers has DPH experienced in their management of the Ryan White CARE Act grant?

4. What ideas does DPH have for the future, e.g., improvements in managing the Ryan White CARE Act grant, changes in Planning Council-DPH communications, modifications to the standards or process for assessment of the administrative mechanism?

Thank you for completing this self-assessment

MOU Basics

What is a Memorandum of Understanding?

Like a contract, a Memorandum of Understanding (MOU)—also known as a Memorandum of Agreement (MOA)—outlines an agreement between two parties, delineating actions and deadlines to which all parties agree to adhere. An MOU, however, is not binding in the same way that a contract is. A contract includes legal components such as indemnification, risk-sharing, and other representations and an MOU does not. An MOU primarily outlines a shared project or set of activities, but does not include penalties for any violations of the agreement.

What to look for in an MOU

An MOU should:

- ▶ Help the agencies' clients access services they need
- ▶ Be feasible—not create an overwhelming amount of paperwork or require unrealistic staff efforts
- ▶ Be for a specific period of time
- ▶ Be reassessed at a specific time
- ▶ Withstand personnel changes
- ▶ Include provisions to help the agencies determine if the agreement is working

Potential components of an MOU

Your MOU may contain some or all the following sections:

- ☐ **Names of the agencies** entering the agreement and their missions.
- ☐ **Overview of the project or activities** governed by the agreement, including the name of the project (if any), authorization granted by the MOU, the project's goals, its intended outcomes, and target clientele.
- ☐ **Each party's responsibilities.** Also, the appropriate place to note that each party will comply with all appropriate local, state, or federal laws and regulations.
- ☐ **A timeline** of when activities will start and end. May also include a timeline for reassessing or renegotiating the MOU.
- ☐ **Duration (or Term) of the MOU.** Some MOUs have a one-year duration, with a provision that the agreement can be extended upon mutual consent. If the MOU is an extension of a previous agreement, it would be noted in this section.

MOU Basics continued

- ☐ **Conditions for termination** other than the end of the project timeline noted above. Might address what happens if funding stops or if one agency cuts its relevant programs and list the mechanism for termination of the MOU (e.g. "termination will occur 30 days after written notice is submitted to the executive director of the other agency").
- ☐ **Personnel involved in the activities or projects**, including staff titles rather than individual names so that future staffing changes do not affect the agreement.
- ☐ **Reporting requirements.** Reports might detail the number of clients referred by the point of entry, the number of clients served, the meetings or training sessions conducted between the two entities, etc. Should include schedule for reports (e.g. monthly or quarterly). Copies of required tracking, evaluation or other forms may be appended to the MOU.
- ☐ **Financial matters.** Although most MOUs do not include any financial relationships, it should be noted if money is changing hands. This would include revenue sharing, compensation, or reimbursement related to staff time, number of referred clients or other costs. Also clarify the schedule and means by which funds will be exchanged (e.g. on a monthly basis by invoice, quarterly reimbursement claims, semi-annual grants, etc).
- ☐ **Mechanisms to protect client confidentiality** within the referral system, addressing requests for information and reporting requirements.
- ☐ **Other requirements** to ensure compliance, cooperation and communication between the parties, such as regularly scheduled meetings, monthly reports, and record-keeping functions.
- ☐ **Signatures** of the executive directors or the chief executive officers of both agencies.

Not all of these sections will be necessary for every MOU. **At minimum, an MOU should include:**

- ▶ Names of the agencies signing the MOU
- ▶ Specific details about the activities occurring under the linkage agreement
- ▶ Clear timeline for the agreement
- ▶ Executive signatures

See **Worksheet #5** for an MOU template.

Memorandum of Understanding

between

and

This agreement is entered into between

and

Organizational Missions

Summary

and

agree to jointly collaborate on the an effort to increase linkages between .

As partners, and agree to .

The parties propose to serve .

Responsibilities

will

will

Timeline and Duration

This MOU shall remain in place from until unless modified in writing before that date. The MOU may be extended for .

Termination

This MOU may be terminated in whole or in part by either party without cause. The MOU will be deemed to be terminated 30 days after written notice of intent to terminate

has been received by the other party. This notification must include the reason(s) for termination. The MOU will terminate automatically if:

In the event of termination, all required reports will be completed through the end of the agreement period.

Personnel

Staff governed by this MOU include:

Points of contact for communication on this MOU will be:

Reporting

A report will be submitted by each agency to the other on a basis.

 will provide .

 will provide .

Finances

Confidentiality

Clients names shall remain confidential as required by state and local law. In addition,

Communication

 and will participate in meetings on a basis.

These meetings will provide an opportunity to assess the referral linkages, referral data and suggest necessary improvements. Other parties are also invited to participate in these meetings as needed.

Signatures

COOPERATIVE AGREEMENT

BETWEEN THE

SEATTLE-KING COUNTY DEPARTMENT OF PUBLIC HEALTH

AND THE

SEATTLE HIV/AIDS PLANNING COUNCIL

INTRODUCTION AND PURPOSE:

The Seattle HIV/AIDS Planning Council (Council) was appointed by the King County Executive in 1992, pursuant to guidelines resulting from the federal Ryan White CARE Act legislation, and to fulfill the Seattle King County Department of Public Health's (Health Department) need for a representative community process to establish HIV/AIDS program priorities. The Ryan White CARE Act legislation, administered by the Health Resources and Services Administration (HRSA), provides Title I funds for Council prioritization for care services to qualified cities.

Funds which come to the Department and are prioritized through the Council for either care or prevention/education programs and services include: federal Ryan White CARE Act Title I and Title II (care), Centers for Disease Control and Prevention (CDC) HIV prevention funding (prevention/education), State of Washington AIDS Omnibus (care - case management, prevention/education) and local funds from King County and the City of Seattle (care and prevention/education). Based on Council-set priorities, the Health Department contracts with community based HIV/AIDS organizations for services and programs.

The Council consists of between 30 and 40 32 volunteers from local communities, with five officers ~~two Co-chairs; one four~~ are elected by the Council from the current Council membership, and the fifth ~~other~~ is appointed by the Health Department as the Prevention Planning Co-Chair.

In 1995, After several years of operation, the Council and the Health Department convened a joint work group to develop three work products which: (1) clarify the roles and responsibilities of each entity; (2) to describe a staffing model; and (3) to develop a conflict resolution model. The intent of this work was to further strengthen the collaborative partnership between the Council and the Health Department, and to maximize the efficiency, and reduce any duplication, of work performed by the Council and the Health Department.

This cooperative agreement serves to package the three products within a written context, to describe stipulations related to the products, to formally recognize the mutual responsibilities of the Department and the Council, and to provide a mechanism by which the Council and the Department can formally agree to the products and stipulations as described.

In 1996, one year after the model was in place, the Council and the Health Department reviewed and revised the three components based upon working experience with the model and changing

circumstances within the relationship between the two bodies necessitated by the CARE Act or staffing changes within the Health Department.

SPIRIT AND INTENT

This Agreement recognizes the common interest and responsibilities shared by the Health Department and the Council in procuring, prioritizing and appropriately allocating care and prevention funding, and in assuring that funded services and programs are evaluated and monitored appropriately. It is the intent of this agreement to acknowledge and foster a spirit of trust, cooperation and full partnership between the Health Department and Council. This Agreement should be interpreted and implemented in a manner that would be understood by any reasonable person.

COMPONENTS OF THE AGREEMENT

The components of this Agreement include:

1. ROLES AND RESPONSIBILITIES

A document entitled "Roles and Responsibilities" (R&R—a Attachment 1) describes the specific work that the Council and the Health Department are required to perform in order to fulfill the stipulations mandated and required by the funders. ~~This document was adopted by vote of the full Council in its regular plenary meeting on May 18, 1995.~~

The Roles & Responsibilities describe the Council's entire scope of work including work which is (a) mandated by federal legislation and (b) determined by the Council as within its purview.

The Roles & Responsibilities describe only that portion of the Health Department's work which: (a) is required in order to fulfill the activities required by HRSA and the CDC, (b) fulfills the Health Department's responsibilities for assessment, policy development, and assurance regarding the receipt, allocation, contracting and monitoring of HIV/AIDS funding, and (c) strengthens the working partnership between the Council and the Health Department. This document does not attempt to describe the Health Department's full range of responsibilities in these areas, but rather serves to distinguish the responsibilities of the Health Department from the Council.

2. STAFFING MODEL

The Staffing Model (a Attachment 2) depicts and describes the organizational structure for the positions funded by Ryan-White the CARE Act and Omnibus which support the work of the Council. these include the Planning Council Coordinator, the Evaluation Coordinator, the Administrative Specialist II, and the Care Planning Coordinator, and the Prevention Planning Coordinator. ~~The Staffing Model was adopted by vote of the full Council in its regular plenary meeting on August 17, 1995.~~

3. CONFLICT RESOLUTION MODEL

A Conflict Resolution Model (aAttachment 3) describes the appropriate steps which ought to be followed in order to resolve conflict between the Health Department and the Council including members and employees. ~~The Conflict Resolution Model was adopted by vote of the full Council in its regular plenary meeting on August 17, 1995.~~

STIPULATIONS OF THE AGREEMENT

The following stipulations apply to the components of this agreement:

1. This agreement and its components will be reviewed annually. If amendments are required (a) by the funders, and/or (b) based upon input from both the Health Department and the Council, the modified agreement should be signed by the Department Director and the Council Co-chairs as of the date of the modification. A description of the Any modification(s) or revisions should shall be amended described into the original agreement.
2. The Planning Council Coordinator will be an exempt employee appointed by the Department Director, and subject to the City of Seattle and/or King County Codes, Charters, and policies and procedures. The Planning Council Coordinator will report to the Regional Prevention Division Director (or Department Director designee) for hiring, performance evaluations and disciplinary issues, and as prescribed by the Conflict Resolution Model. The Planning Council Coordinator will confer with the Council Officers Co-chairs regarding work assignments and day to day operations.
3. The Planning Council Coordinator will be hired by the Department via a collaborative hiring process which may include input from the Council Co-chairs, other Council members, and Health Department staff, as determined by the Regional Prevention Division Director (or Department Director designee.)
4. An annual performance evaluation of the Planning Council Coordinator will be initiated by the Department ~~according to the following schedule~~, and will be conducted in collaboration with the Planning Council Officers co-chairs. The evaluation will be signed by the Regional Prevention Division Director (or Department Director Designee). The performance evaluation will reflect input from Council members, the community, and pertinent Department staff, as gathered by the Officers Co-chairs and the Regional Prevention Division Director.

~~Performance Evaluation Schedule: 3 months, 7 months, 10 months and annually thereafter.~~

As a condition of appointment to the positions of Planning Council Officer Co-chairs, candidates must demonstrate either (a) relevant supervisory experience and skills, and/or (b) agree to obtain supervisory skills training at Council expense (for the elected Co-chair) upon election/appointment to office Co-chair.

6. ~~The Planning Council Coordinator position will be a full time position, 1.0 FTE. If, after one year from the date of hire, it is determined, through consultation with the Council Co-chairs and input from the full Council, Department staff, community members, etc., as applicable, that the job duties of the Council Coordinator are less than full time, the Regional Division Director (or Department Director Designee) may reduce the position to the appropriate FTE level.~~

67. It is the intent of the staffing model and this agreement to acknowledge that the Council-designated positions funded by Ryan White the CARE Act and Omnibus, including the Planning Council Coordinator, Evaluation Coordinator, Administrative Specialist II, Evaluation Specialist, and Care Planning Coordinator, and Prevention Planning Coordinator, will shall work in full partnership, collaboration and in a collegial spirit with other Health Department staff. This shallwill take the form of mutual support and respect, and shallwill foster and maintain a close working relationship between the Council and the Health Department. The Council Coordinator shallwill work closely with the Community AIDS Services Unit Program Manager, and with all other Health Department staff to ensure the production of timely, efficient, well planned and high quality products and processes that meet federal, state and local funding guidelines. Whenever conflicts arise regarding the use of staff time or materials, ideas or opinions, behavior, procedural issues, efficiency, etc., the involved parties should endeavor to-shall use the Conflict Resolution Model for resolution of the problems.
7. The Planning Council Coordinator will supervise the Administrative Specialist II and the Evaluation Coordinator Specialist who will be employed by the Department and subject to Career or Civil service policies and procedures. (The Care Planning Coordinator and the Prevention Education Coordinator report to the AIDS Program Manager CASU manager - see Attachment 2.) The Planning Council Coordinator will receive input from the Council Co-chairs and will work in conjunction with the Regional Prevention Division Director (or Department Director designee) to prepare and conduct performance evaluations for these positions; input will be gathered from Council members and Health Department staff as applicable.
8. The Health Department and the Council pledge to conduct their respective roles and responsibilities as depicted in "Roles and Responsibilities," Attachment 1, under agreed upon time lines, in a spirit of cooperation and partnership, and acknowledge the inter-dependence of their roles and responsibilities in acquiring and spending Federal funding, and assuring that all stipulations of the funding are fulfilled.

COOPERATIVE AGREEMENT UNDERSTANDING

Our signatures indicate our understanding and acknowledgment of this agreement and its component parts, including the Roles and Responsibilities, the Staffing Model and the Conflict Resolution Model:

**For the Seattle King-County
Department of Public Health:**

**For the Seattle HIV/AIDS
Planning Council**

Alonzo L. Plough, PhD., MPH
Department Director
Date _____

Margo Bykonen, RN
Planning Council Care Co-Chair
Date _____

Robert W. Wood, MD

Lupe M. Lopez

AIDS Control Officer and
Council Prevention Co-Chair
Date _____

Planning Council Prevention Co-Chair
Date _____

Roles & Responsibilities

Final Version
Approved by the Planning Council on
May 18, 1995

Revised Fall 1996

COMPREHENSIVE PLAN

Planning Council Member Responsibilities	Health Department Responsibilities
1.a. Overall responsibility for development of a 5-year care comprehensive plan for the period 1996-2000 consistent with existing plans. 1.b. Review the plan annually and update every five years. 2.a. Overall responsibility for development of a prevention/education comprehensive plan in compliance with CDC guidelines and timelines. 3.2.b. Review the plans annually and update as needed every 5 years.	1. Actively support, provide technical assistance for and critical input to the development, monitoring and updating of the care comprehensive plan. 2. Actively support, provide technical assistance for and critical input to the development, monitoring and updating of the prevention/education comprehensive plan.

CONTRACTING OVERSIGHT, MONITORING AND ASSURANCE

Planning Council Member Responsibilities	Health Department Responsibilities
1. Review standard quarterly reports from the Health Department identifying amounts of resources allocated to each set category, and the date contracts were signed. Planning Council decisions were made, the date funds were disbursed, etc., projections and objectives. 1.1 Verify that final allocations are within established ranges set during the prioritization process and that the allocations were made during set time frames. 2. Confirm Assure that allocations and contracts support the overall vision and priorities of the long range comprehensive plan. 2.1 Review standard reports that show the correspondence between the Planning Council priorities and the long range plan. 3. Set criteria for responsiveness of the grantee and agencies in establishing contracts.	1. Ensure compliance with that direction and the requirements of the CARE Act, Ryan White and CDC, and the King County procurement office, grants are met. 2. Contract with agencies and monitor contracts to ensure that agencies meet requirements. 3. Provide abstract summaries of funded proposals to the Planning Council for review. Prepare standard quarterly reports identifying amounts of resources allocated to each set category, the date Planning Council decisions were made, the date funds were disbursed, etc. 3.1 Negotiate report formats with the Planning Council.

NEEDS ASSESSMENT

EVALUATION

Planning Council Member Responsibilities

1. Develop a prioritized 3-year evaluation plan consistent with CARE Act and CDC guidelines.
2. Review and update a prioritized 3-year evaluation plan at least annually.
 - 2.1 Identify and prioritize evaluation questions for prevention/education and care.
3. Interact and collaborate with other evaluation agencies and evaluators to provide complementary and non-duplicative evaluation activities.
4. Implement the prioritized 3-year evaluation plan
5. Provide technical assistance to agencies for evaluation within allocated funds and the prioritized evaluation plan.
6. ~~Review evaluation products and provide them to the needs assessment committee.~~

Health Department Responsibilities

1. Identify evaluation questions for care and prevention/education that are important to the Health Department and integrate them with other questions from the Planning Council and community.
2. Review and provide critical input to the prioritized 3-year evaluation plan.
3. Provide technical support (e.g. data, program reports, etc.) to the Planning Council's effort for providing evaluation technical assistance to agencies.
4. Review evaluation products and use them to inform the needs assessment and allocation process.

COMMUNITY RELATIONS

Planning Council Member Responsibilities	Health Department Responsibilities
1. Develop and maintain a communication <u>systems</u> ~~sleep~~ which assure that information is <u>shared</u> with affected and interested communities. 2. Develop and use a mechanism to communicate the Planning Council's work and decisions. 3. Identify and plan to overcome barriers for the participation of diverse populations in Planning Council business.	1. Develop and maintain a communication <u>systems</u> ~~sleep~~ which assures that information is shared with affected and interested communities. 2. Develop and use a mechanism to communicate the Health Department's work and decisions.

ADVOCACY

Planning Council Member Responsibilities	Health Department Responsibilities
1. Develop <u>independent</u> positions on issues and present them in appropriate venues in collaboration with others. 2. Participate actively and collaboratively in matters affecting care or prevention <u>education</u> policies and resources.	1. Develop <u>independent</u> positions on issues and present them in appropriate venues for advocacy <u>in collaboration with others</u>. 2. <u>Participate actively and collaboratively in matters affecting care or prevention policies and resources.</u> 23. Provide data, advice and other assistance to the Planning Council to inform advocacy <u>efforts</u>. 3. <u>Advocate through appropriate channels for resources and public health policies.</u> 4. <u>Support the Planning Council's efforts for advocacy.</u>

ADVOCACY

Planning Council Member Responsibilities	Health Department Responsibilities
1. Develop <u>independent</u> positions on issues and present them in appropriate venues in collaboration with others. 2. Participate actively and collaboratively in matters affecting care or prevention, education policies and resources. <i>Assign to each committee in its area of expertise (ex: recent managed care and positive voice letters). Secure approval at Executive Committee.</i>	1. Develop <u>independent</u> positions on issues and present them in appropriate venues for advocacy in collaboration with others. 2. <u>Participate actively and collaboratively in matters affecting care or prevention policies and resources.</u> 3. <u>2</u> Provide data, advice and other assistance to the Planning Council to inform advocacy efforts. 3. <u>3</u> Advocate through appropriate channels for resources and public health policies. 4. <u>4</u> Support the Planning Council's efforts for advocacy.

Other Suggestions:

1. a. *We do not need to duplicate the good work of the Northwest AIDS Foundation's Public Policy Committee. Send two Council representatives there (one each from care and prevention planning) for coordination and information sharing.*
[Note: NWAFF would have the opportunity to ratify our appointment.]
 - b. *Put Council members on "Communities in Action" mailing list.*
 - c. *Circulate web address and contact list.*
2. *Provide advocacy training annually for Council/committees.*
3. *Include advocacy work and outcome in annual review of Council accomplishments.*

**PLANNING COUNCIL ROLES AND RESPONSIBILITIES
RELATED TO COMMUNITY RELATIONS/ADVOCACY
PROPOSED COMMITTEE ASSIGNMENTS**

Seattle-King County

Conflict Resolution Model

**Final Version
Approved by the Planning Council on
August 17, 1995**

Revised Fall 1996

Model for Resolving Conflict

Focus on Planning Council/Staff/Health Department Conflicts

SCOPE OF MODEL:

This model attempts to deal with conflicts that arise among the Planning Council, the Planning Council staff and/or the Health Department. This might include but is not limited to:

- a. Differences over the performance expectations or roles of the Planning Council Staff, the Planning Council and the Health Department.
- b. Differences in understanding and interpretation of technical data and analysis.
- c. Personal misunderstandings between Planning Council Members and Planning Council Staff or Health Department Staff.

GUIDING PRINCIPLES:

1. **Participation.** Involving people, early on, in the development of information and in the decision making process may help to prevent conflicts that stem from differences in data interpretation or influence.
2. **Assertive Problem-Solving.** Face-to-face problem solving (including the assertive expression of needs, wants, interests, feelings and limits) is the method of choice regardless of the level at which the conflict is generated, resolved, or who is involved.
3. **Resolution First Among the Parties Themselves.** Parties should attempt to resolve conflict at the local level first—between the parties themselves who are directly involved in the conflict when it first arises.
4. **Move To Next Step If Necessary.** If the conflict can not be resolved between the parties themselves, one or all of the parties may take the issue to the next step of resolution. The party taking the issue to the next step must submit written documentation of the specific area of conflict and summarize reasons why initial resolution efforts were unsuccessful. The people representing the next step will help the parties engage in problem solving.
5. **As Soon As Possible.** Conflicts should be resolved at the first opportunity for discussion. Any or all parties may take the issue to the next level of resolution if, after 10 days, the issue remains unresolved at that level. The resolution of any conflict should not exceed 30 working days.

Recommendations:

1. ~~To the Planning Council Governance Committee:~~ Develop a set of guidelines to clarify the role of a Planning Council Member when there is a conflict between a client and a contracted agency. Request that the staff brief the Planning Council on these guidelines.
2. ~~To the Health Department:~~ Include in the contract boiler plate a provision requiring agencies to maintain or submit a copy of their written "client/consumer grievance procedure".
3. ~~To the Planning Council Co-Chairs:~~ Develop job descriptions for the Planning Council Co-Chairs, and the Committee Co-Chairs.

GUIDANCE ON CONFLICT EXTERNAL TO THE COUNCIL AND HEALTH DEPARTMENT:

At times, individuals from the community may approach Council members about a concern or conflict he or she has with a specific agency. Council members shall direct such individuals to pursue the resolution of that conflict with the agency directly, utilizing that agency's conflict resolution/grievance process. Due to conflict of interest, it is inappropriate for the Council to consider client/agency conflicts. The Health Department may become involved in the resolution of such conflict if it entails a breach of contract related to service delivery concerning a Health Department funded progr

	Planning Council Member Conflict With Planning Council Staff (or vice-versa)	Planning Council Member Conflict with Health Dept. Staff (or vice-versa)	Health Department Conflict with Planning Council (or vice-versa)	Planning Council Coordinator Conflict with Planning Council Co-Chairs (or vice-versa)	Planning Council Staff Conflict with Health Dept. Staff (or vice-versa)	Planning Council Member Conflict with Council or Committee
Step One	Parties Themselves	Parties Themselves	Parties Themselves	Parties Themselves	Parties Themselves	Parties Themselves
Step Two	Planning Council Co-chairs & Planning Council Coordinator	AIDS Program Manager & Planning Council Co-Chairs	Planning Council Co-chairs & Prevention Div. Director	Prevention Div. Director & PC Executive Committee	Planning Council Coordinator & AIDS Program Manager	Member and Council Co-Chairs/Parliamentarian
Step Three	Planning Council Co-Chairs & Prevention Div. Director	Prevention Division Director & Planning Council Co-Chairs	Planning Council Executive Committee, and Prevention Div. Director	Dept. Director and Planning Council	Planning Council Co-Chairs & Prevention Div. Director	Member and Executive Committee
Step Four	Dept. Director & Planning Council Co-Chairs	Dept. Director & Planning Council Co-Chairs	Full Planning Council & Prevention Div. Director or Dept. Director Designee	Dept. Director & King County Executive	Dept. Director & Planning Council Executive Committee	King County Executive
Step Five	King County Executive	King County Executive	King County Executive HRSA CDC State of Washington		Dept. Director & King County Executive	

1. "Department" refers to the Seattle-King County Department of Public Health
2. Wherever this matrix indicates the "Prevention Division Director," it implies "or Department Director designee"
3. Wherever this matrix indicates the "Department Director," it implies "or Department Director designee"
4. Wherever this matrix indicates the "King County Executive," it implies "or Executive designee"

Memorandum of Understanding:

Planning Council Evaluation of the Administrative Mechanism

As adopted by the Planning Council, October 2000; revised September 2001

Although not organized into a formal report, the Council has long assessed the efficiency of the administrative mechanism through a number of means. In the FY2001 application, the EMA has pledged to organize all the existing assessment activities (e.g. reports on allocation of funds, procurement, spending rates, implementation of priorities and guidance, etc.) into a formalized process, and to strengthen that process with new assessment tools.

Currently, the Council's Executive Committee (EC) and finance officer oversee the financial aspects of EMA's Title I program and review all assessment activities. The finance officer receives briefings on fiscal and administrative matters, and is invited to participate in biweekly Title I staff coordination meetings with Council and Grantee staff where administrative issues are discussed. The EC will continue in its role as the Council's oversight body for the administrative mechanism. This is subject to the approval of the full Council. The Executive Committee will be responsible for making sure that the activities described are completed on the timetable laid out below.

The Grantee agrees to provide the following reports:

- *Monthly:* The Grantee provides oral reports to the Executive Committee on the status of RFPs, procurements, contract negotiation issues, and re-programming plan implementation. Information provided includes information on process and outcomes (e.g. timeliness, services procured, match of awards to PC priorities and allocations, geographic distribution of services compared with PC-designated areas of high need). The report will also contain information on current administrative issues (e.g. spending rates, reimbursement policies, etc.).
- *Quarterly:* The Grantee will compile the previous three months of status reports into a written report, to be submitted to the EC on a timeline consistent with the schedule of quarterly reports from MHRA and Westchester County Department of Health to NYCDOH

(i.e. 60 days after the close of each quarter). The timeframe for quarterly reports is as follows:

Quarter	Report to DOH	Report to MO/APC
3/1 to 5/31	7/15	8/1
6/1 to 8/31	10/15	11/1
9/1 to 11/30	1/15	2/1
12/1 to 2/28	4/15	5/1

- **Annual:** The Grantee will supply MO/APC a copy of the Annual Report submitted to HRSA. This report is due to HRSA no later than May 31 and a copy should be submitted to MO/APC at the same time. The Grantee will present the report during the June Planning Council meeting.
- **September:** The Grantee provides a formal, written response to the Planning Council's priority and guidance for the following fiscal year (i.e. the priorities and guidance approved the previous July for the application) provided the Planning Council's priorities are submitted to the Grantee by the end of July. The response will include the Grantee's plans to implement the priorities and potential difficulties that the Grantee and/or Council may need to address. The Grantee shall clearly demonstrate what their anticipated difficulties in implementing the guidance, citing specific Ryan White regulations to support them and suggestions for corrective action to the Planning Council.
- **October:** In anticipation of a higher award and the implementation of new priorities by competitive bid, the Grantee provides a draft of the RFP to Planning Council staff for review to determine that it reflects the Council's priority templates. The same process will be followed for other RFPs as needed.
- **November:** The Grantee provides the Planning Council with the final Program Monitoring Report (PMR) for the fiscal year ending the previous February. The PMR details aggregate services by Title I providers, including descriptions and demographics of clients served.
- **End of April:** The Grantee provides a copy of a preliminary report of the new fiscal year's spending rates and estimates of projected unexpended funds (accruals) to MO/APC. This report will be presented by the Grantee to the Planning Council in May. This will be used in the Council's preparation of a prioritized reprogramming plan.

- *June:* The Grantee provides the Planning Council with a final report on the previous fiscal year's spending (carry-over), and the current fiscal year's commitments for the Council's preparation of a plan for reprogramming.
- *Annual:* The Grantee produces an annual New York City Title I service directory and will post the service directory on the DOH web site. The Title I directory will contain every program funded under Ryan White Title I for New York City and it is the responsibility of the Grantee to insure the accuracy of the directory. In addition, the Grantee will provide an addendum to the directory on a yearly basis listing the agencies funded, the service for which they receive funds and the contract amount of this service.
- *As Needed.* There may be special requests from the Planning Council for information from the Grantee concerning the administration of the Title I program. The Council and Grantee will establish parameters (e.g. feasibility, mechanisms for delivery, deadlines) for each request on an individual basis.
- The Grantee will submit to the Planning Council, for the Council's review, all federal audits of the Title I program. The Grantee will also provide to the Council written notices of any and all federal audits within 5 days of receipt of notification of audit by the federal government. This notification will be sent to the Governmental Chair and the Community Chair of the Planning Council.
- The Grantee will send to the Planning Council in care of MO/APC Citywide Coordinator of AIDS Services the Notice of Award and any Special Conditions of Award from HRSA. This is to be done not longer than 10 days from the time that the Grantee is notified in writing from HRSA.
- *Ongoing* The Planning Council will use CHAIN studies, PC funded studies and other planning data to collect overall information on system outcomes, unmet needs, etc.
- *Tri-County.* The Tri-County Steering Committee has the option to develop a plan, in collaboration with the Westchester DOH, to evaluate the administrative mechanism in the Tri-County region. A written evaluation will be submitted to the full Council no later than June 30 provided Tri-County exercises its option to evaluate their administrative mechanism.

Options for Other Planning Council Evaluation Activities

- The Planning Council may choose to undertake a survey of sub-contractors on the procurement and contracting process.
- The Planning Council may choose to undertake a survey of Council members on the responsiveness of the Grantee to the priorities identified by the Council.
- The Planning Council may choose to undertake an independent audit of the Grantee's activities for further assessment of the Grantee's fiscal administration of the Title I program. The Grantee agrees to cooperate with any independent audits and provide requested information in a timely manner.
- The Planning Council reserves the right to request additional information from the Grantee not required by HRSA in order to improve its evaluation of the administrative mechanism. The Grantee agrees to provide this information in a timely fashion.

The EC will create a formal written evaluation that will be submitted for approval to the full Council in July for inclusion in the annual Title I application. The report will contain a synthesis of all the evaluation information obtained from the above activities. The report will assess the Grantee's responsiveness in the delivery of the reports outlined above, and in its fulfillment of its roles and responsibilities regarding the administration of the Title I program. The Grantee will have an opportunity to review and comment on the report before it is finalized for submission in the application.

For the HIV Planning Council:

For the Grantee:

Governmental Co-Chair

Associate Commissioner of Health/HIV Services

Community Co-Chair

Finance Officer



LAFRANCE ASSOCIATES

DOCUMENTS DEPT.

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**San Francisco
2002 HIV/AIDS NEEDS ASSESSMENT REPORT**

**Prepared for
the San Francisco HIV Health Services Planning Council**

May 2002

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13. SUMMARY AND CONCLUSION

Epidemiological Estimates and Trends

At the beginning of 2001, San Francisco and San Mateo counties had an estimated 19,000 to 21,000 PLWH/A. At the end of 2000 there were about 8,900 persons known living with AIDS, leaving over 12,000 people living with HIV or who don't know they are living with AIDS. The trend is for an increased number of PLWH/A in the care system. Since 1997 there has been an 11% increase in PLWA, and it is estimated that there will be an even greater increase in persons newly infected with HIV. This suggests an annual growth rate of between 4% and 5% in people needing care services a year. MSM will continue to be the majority of PLWH/A. New infections will increase disproportionately among African Americans, Latinos, women, and heterosexuals.

Demographics of PLWH/A

The distribution of PLWH/A according to the weighted data in the survey is:

- 92% males, 6% females, and 2% transgender
- MSM represent the largest proportion of PLWH/A at 74%, followed by MSM/IDU at 13%, (non-MSM) IDUs at 11%, and heterosexuals at 3%. According to the 2000 Epidemiological report, MSM are 86% of living AIDS cases and an estimated 87% of PLWH/A in San Francisco and 72% of PLWA in San Mateo. The most recent HIV prevalence and incidence estimates produced by the San Francisco Department of Public Health (SFPDH) project a significant increase in new HIV infections among MSM in San Francisco, especially MSM/IDU. Young gay men, particularly young gay men of color, are becoming infected at an alarming rate.
- The majority of the PLWH/A is non-Latino Anglo (69%), followed by African Americans (14%), Latinos (13%), Asian/Pacific Islanders (4%), and Native Americans (<1%).
- African Americans and Anglos are both disproportionately infected with HIV when compared to their share of the total population, and Native Americans have a slightly higher proportion of HIV cases.
- People of color, especially African Americans, make up an increasing percentage of new AIDS cases and estimated HIV infections in San Francisco. One-third of all PLWH are people of color. African Americans comprise only 5% of the San Francisco EMA's population yet they are nearly 15% of PLWA, 18% of estimated HIV infections, and 23% of people newly diagnosed with AIDS.
- Latinos are not disproportionately affected by HIV. Latinos are 17% of the EMA population, 13% of those living with AIDS, and 13% of estimated HIV infections. According to the Title I application, Latinas are 14% of cases among women but they are disproportionately represented among women who are not IDUs, with 21% of living AIDS cases.
- Women represent between 5% and 6% of all PLWH/A. According to the survey, 37% are African American.

- Almost three-quarters of heterosexuals living with HIV/AIDS are women, and they represent over a third of the IDUs.
- Women with AIDS are much more likely to be symptomatic than asymptomatic. Women are particularly vulnerable to Hepatitis C, with a co-morbidity with HIV infection of over 60%.
- About 80% of the women living with HIV/AIDS are living with others, including infected children and adults. This is more than double the percentage of men living with others.
- Transgender persons represent about 2% of all PLWH/A, but they are among the most vulnerable population for HIV infection. Over three-quarters are people of color and they were largely infected through sexual contact.
- Transgender PLWH/A have high rates of homelessness and drug use, and are much more likely than other populations to have contact with the jails or prisons. They are more likely to be out-of-care than most other populations living with HIV/AIDS, and they are more likely to have stopped taking their medication. By any measure, transgender PLWH/A have the greatest unmet needs and highest barriers of all subpopulations.

Education and Workforce

- PLWH/A in San Francisco are fairly educated. About 12% have less than a high school education, and 19% have post graduate education.
- Latinos, undocumented PLWH/A, those out-of-care, and recently incarcerated PLWH/A (many individuals are in most or all these categories) have the lowest education level.
- The majority of PLWH/A are not currently working (63%). Twenty percent of those not working are actively looking for work and 38% are not looking for work. Twelve percent of the sample is retired and 25% are either employed part- or full-time.
- More women (55%) and transgender PLWH/A (64%) are not working and not looking for work than are men (36%). However, a larger percentage of women are employed full time (15%) than men (10%).
- Among ethnic populations, APIs have the highest percent of PLWH/A who are currently employed full-time at 33%. Native Americans have the lowest percent of persons employed full-time at 3%.
- More Latinos (29%) report looking for work than any other ethnic group.
- Interestingly, being symptomatic is a better indication of being out of work and not looking for work than having AIDS. Over 40% of HIV symptomatic (43%) and AIDS symptomatic (46%) report not working and not looking for work.

Income

- In general, the participating PLWH/A have low incomes. About 75% report earning less than \$16,500, and approximately 36% report earning less than \$8,600.
- Females report significantly lower income than males. Transgender PLWH/A report the lowest income of any gender group with 69% earning \$8,600 or less per year compared to 34% of males and 47% of females.

- Among risk groups, the vast majority of IDUs (93%) and MSM/IDU (87%) have incomes of \$16,500 or less per year. MSM have the highest income with 21% making more than \$23,000 followed by heterosexuals (15%), MSM/IDU (11%), and IDUs (6%). Even among MSM, less than 3% report earning more than \$35,000 – the usual limit to qualify for ADAP.
- Over half the Latinos and African Americans report earning \$8,600 per year or less.
- Not surprisingly, homeless PLWH/A and those out-of-care report the lowest income.
- For drug reimbursement, a PLWH/A has to be below 400% of the federal poverty level. Over 95% of the participants in the needs assessment survey would meet the financial criteria for ADAP.

Age

Not surprisingly the newly infected populations are younger than those with AIDS. Among ethnic groups, Latinos are the youngest group, and among risk groups heterosexuals are the youngest. Both these groups have relatively high rates of new infections.

State of Infection

- About 59% of PLWH/A have been diagnosed with AIDS (slightly higher than the most current estimates by SFDPH).
- Those with AIDS have a low mortality rate, and those infected with HIV are likely to progress to AIDS slowly. With the current growing infection rate among young gay men and communities of color, those newly infected will increase the proportion of those HIV positive who have not progressed to AIDS.
- Perhaps more important to the care system, just over 60% of the participants of the survey said they were symptomatic. Throughout the data, one finding that stands out is that the onset of symptoms is a better predictor of service need than a diagnosis of AIDS.
- Those newly infected – the poor, those with co-morbidities of substance use, homelessness, and mental illness – are more likely to be symptomatic and thus require more services.
- Based on the criteria for antiviral treatment, 70% of the HIV positive populations, or nearly 8,000 persons in the care system are candidates for treatment because of an AIDS diagnosis, low t-cell counts, or OIs.

Co-Morbidities

Homelessness and Housing

- Almost half of the newly diagnosed PLWA have been homeless for some length of time since being diagnosed. This again highlights the heightened vulnerability of and greater need of this population.
- African Americans are more likely to have a history of unstable housing and live in transitional housing than other ethnic groups.

- Among risk groups, IDUs and MSM/IDU are much more likely to have been homeless or lived in transitional housing than MSM or heterosexuals.
- Recently incarcerated PLWH/A are far more likely to experience a period of homelessness than other populations. Nineteen percent of all PLWH/A report having a history of being homeless compared to 77% of those who have been incarcerated in the last two years. This may reflect the financial challenges and rules and regulations of public housing one faces after being released from the jail system.
- About half (52%) of the out-of-care and symptomatic PLWH (49%) report being homeless in the last two years.
- Men are less likely to have a history of homelessness or living in transitional housing than women or transgender PLWH/A.
- APIs (8%) and Latinos (17%) report a much lower incidence of homelessness.

Substance Abuse

- Just under a quarter of PLWH/A can trace their infection back to drug use, although current use is much lower.
- Still, drug use has been mentioned by many PLWH/A as their reason for not seeking care or delaying care.
- Of the opiates, 47% of the PLWH/A report ever using crack/cocaine and 19% report ever using heroin. About 13% have used crack/cocaine in the last six months and 9% of PLWH/A who use crack or cocaine say they continue to use the drugs more than once a week. About two percent of those who ever used heroin have used it in the last six months.
- The recently incarcerated (22%), out-of-care (27%) and the currently homeless PLWH/A are more likely to use crack than other populations. The recently incarcerated, homeless, symptomatic PLWH and women are among the highest current users of heroin, indicating the high level of co-morbidities among these populations.
- While almost half (45%) of PLWH/A in San Francisco say they have used crystal meth, less than 10% report using it frequently (once a week or more).
- “Party drugs” include poppers, ecstasy, and Gamma Hydroxybutyrate (GHB) are known to be related to unsafe sexual practices. Nearly half (47%) of the PLWH/A report using poppers, with more than 20% saying they use it monthly. One quarter (24%) of all PLWH/A say they have used ecstasy, but it is not frequently used. MSM/IDU, API and symptomatic PLWH tend to use GHB more than other populations, with more than 40% of the API reporting monthly usage.

STDs

- Nearly one quarter of the PLWH/A report having been diagnosed with hepatitis C in the last year. Predictably, the incidence of hepatitis is significantly higher among IDUs (76%) and MSM/IDU (41%).
- Among ethnic communities, the incidence of hepatitis C is highest among African Americans (50%). An alarming 61% of the women report having been diagnosed with hepatitis C over

the past year. This is particularly true for 78% of the African American women who report having hepatitis C. Also, half of recently incarcerated PLWH/A report having had hepatitis C.

- The next highest incidence of STDs is hepatitis A or B (14%). It is significantly higher among women (25%), Native Americans (34%), and IDUs (25%). Among the special populations, PLWH/A living in the Tenderloin district, undocumented PLWH/A, recently incarcerated PLWH/A and persons with symptomatic AIDS report the highest incidence of hepatitis A and B.
- Herpes is the third most frequently reported STD (11%). It is highest among transgender PLWH/A, recently incarcerated PLWH/A, and symptomatic PLWA.

Mental Illness

- Depression has been diagnosed among 51% of PLWH/A in the past two years, and it is the most frequently diagnosed mental illness reported by PLWH/A. It tends to be highest among Native American (57%) and IDUs (58%). API (42%) report less than the average incidence of depression.
- Women (69%) and transgender PLWH/A (65%) have the highest incidence of depression. Asymptomatic PLWA (40%) report the lowest.
- More than one third of PLWH/A (38%) report a diagnosis of anxiety in the past two years. Native Americans (52%), Anglos (40%) and IDUs (44%) tend to have received a diagnosis of anxiety more than any of the other ethnic and risk groups.
- Thirteen percent of PLWH/A report bipolar disease, with Native Americans (34%) reporting a significantly higher incidence than any of the other populations.

Health Care System for PLWH/A

Insurance

- More than 40% of the PLWH/A who were surveyed reported having no form of insurance. Transgender PLWH/A (63%), APIs (60%) and PLWH/A in San Mateo (71%) are more likely to report not having insurance than other populations of PLWH/A.
- Medi-Cal / Medicaid are by far the most common form of insurance for all populations infected with HIV/AIDS in the San Francisco area, with transgender PLWH/A, Native Americans, and MSM/IDU being the groups most likely to have this type of insurance.
- Forty percent of all those with insurance report Medi-Cal / Medicaid as their sole form of insurance. Medi-Cal / Medicaid is the sole insurer for more than half of the women, transgender PLWH/A, African Americans, IDUs, and heterosexuals
- One-third of the insured PLWH/A report having some form of private insurance as their only source of insurance. Men are much more likely to report having private insurance and about 40% of the APIs, MSM and asymptomatic PLWA report having private insurance as their sole coverage.

- Twenty-two percent of the insured PLWH/A report Medicare as their sole coverage. Medicare is the primary insurer for youth and persons 55 years of age or older. Also, more than one third of the APIs report Medicare as their sole insurer.
- Over 55% of the PLWH report not having any form of insurance, while fewer PLWA (47% asymptomatic and 20% symptomatic) report no insurance.
- A slightly larger percentage of women (62%), on the other hand, report having insurance than men (58%). This is the usual pattern for EMAs because of the various Medicaid programs for families and single mothers with children.
- Sixty-two percent (62%) of Anglo PLWH/A report having insurance compared to about 50% of African Americans and Latinos. Interestingly, MSM/IDU (70%) are the group most likely to be insured while heterosexuals (48%) are the group least likely to report having any form of health insurance.
- Symptomatic PLWA report the highest levels of insurance (80%).

Drug Reimbursement

- The data suggest that PLWH/A do not have a clear sense of how their medication is purchased with up to 20% report not knowing the amount of prescriptions paid for by any of their sources of drug reimbursement.
- Sixty-one percent and fifty-seven percent of the PLWH/A report that ADAP or Medi-Cal / Medicaid paid for their medications, respectively.
- Forty-five percent of the PLWH/A report that their medication was reimbursed by private insurance, 30% report out of pocket medication cost, and nine percent report receiving VA benefits to cover their medications.

Disability

Less than 30% of PLWH/A report being on long-term disability. As expected the rate of disability is higher among those infected earlier, such as males, Anglos, MSM, and symptomatic PLWA. Latinos, heterosexuals, women, and youth are the least likely to receive long term disabilities.

Entitlements and Benefits

- Indicative of the low income of PLWH/A, more than one-third (36%) report receiving SSI and 17% report receiving a housing subsidy. Females, transgender, MSM/IDU, IDUs, African Americans, persons over 55 years old, and PLWA are more likely to receive SSI. However, these same groups are not necessarily more likely to receive rental subsidies. Males and transgender PLWH/A are more likely than females to receive rent subsidies; APIs and Native American are more likely to receive rent subsidies than other ethnic populations; and MSM/IDU and MSM are more likely to receive rental subsidies than other risk groups.
- About 19% of the PLWH/A report receiving direct emergency financial assistance (DEFA), usually used for utilities, rent, or emergency medical treatment. However, women, African

Americans, Latinos, and heterosexuals, San Mateo residents, homeless, the out of care, youth and PLWH are the least likely to receive DEFA.

- Surprisingly, only 11% report receiving food stamps and three percent report receiving TANF/CalWorks. African Americans (21%), youth (32%), recently incarcerated (31%), homeless (33%), the out of care (30%) are much more likely to receive food stamps than any other group.

Out-of-Care and Delayed Care Seekers

- Based on the REGGIE system and San Mateo and Marin county records there are about 11,000 PLWH/A in the EMA who receive one or more of the Ryan White funded services. An estimated 12,760 PLWH/A receive outpatient care, including 4,260 reported from REGGIE plus about 8,500 receiving care outside the Ryan White Care System. This would leave an estimated 13% who know their status, are eligible for Ryan White outpatient funded care, and are not receiving services.
- A newly diagnosed PLWH/A who has not seen a primary care physician within six months is considered to be unconnected to care. Thirty-four PLWH/A report waiting more than six months to see a physician after receiving their HIV diagnosis, or about six percent of the sample, but this is unlikely to be generalizable due to small sample sizes.
- Any PLWH/A who knows his/her infection for over six months, and has not seen a physician in over a year, regardless of previous care practices, would be considered unconnected to care. Nine PLWH/A report not seeing a doctor in more than 12 months and are considered to be currently out of care, or less than 2% of the sample would be considered currently out-of-care. Notably the sample is mostly recruited from providers of HIV/AIDS care services. Again small sample sizes may make this unreliable, but it does indicate that those who are connected to the care system are currently out-of-care.
- Based on the consumer survey, the majority of the delayed care seekers (78%) as well as the unconnected to care (67%) are men. However, a greater proportion of the women are more likely to delay or to be unconnected to care than the proportion of women in care. Also, women are more likely to be unconnected to care than to be delayed care seekers.
- African Americans are disproportionately represented among those out-of-care. While the same proportion of Anglos and African Americans delay care, Native Americans, Latinos and African Americans are proportionately much more likely to delay care.
- Among the risk groups, heterosexuals are the smallest group among those that delay or are unconnected to medical care. However, MSM/IDU, IDU, and heterosexuals are disproportionately represented among those unconnected to and delaying medical care.
- About one third of the delayed care seekers (31%) and the unconnected to care (35%) have known their HIV status for less than three years compared to less than 20% of the total sample of PLWH/A. A greater proportion of the unconnected to care (53%) report being asymptomatic compared to the delayed care seekers (35%) or the overall sample of PLWH/A.
- Among all PLWH/A, whether in care or not, forgetting to take the medications was the number one reason for not adhering to medications. For the delayed care seekers and the

unconnected to care, running out of medicines was also among the top reasons for not adhering. For the unconnected to care, difficult scheduling was also an important factor.

- A higher proportion of the delayed care seekers and the unconnected to care report high incidence of hepatitis C compared to the overall sample of PLWH/A. About 30% of the unconnected to care and 47% of the delayed care seekers have had hepatitis C since being diagnosed with HIV. Delayed care seekers and those unconnected to care report a higher incidence of syphilis than other PLWH/A.
- Delayed care seekers and the unconnected to care are much more likely to currently be using substances than other PLWH/A. More than half report using alcohol, crack/cocaine, and marijuana.
- Qualitative comments emphasize the relationship between active drug use and delaying care or being out-of-care.

Improved Outcomes (Physical and Emotional Health)

While there is no trend data, it would be expected that a successful continuum of care would continue to keep persons in good physical health, including those with AIDS. Overall, based on improvement in both physical and emotional health, the care system is making an impact. Those with AIDS appear to show the greatest improvements. HIV symptomatic populations are having the worst outcomes, indicating that the newly infected with symptoms are having the most difficulty in the care system.

Medication and Adherence

- Seventy-seven percent of all PLWH/A report taking medicines to treat their HIV infection, but there is a linear relationship with stage of disease, with 93% of symptomatic PLWA reporting taking medication.
- Females are more likely to have taken HIV medications (82%) than either males (77%) or transgender persons (56%). Undocumented PLWH/A, persons out-of-care, recently incarcerated PLWH/A, and homeless PLWH/A report a much lower use of medication. Over two-thirds (67%) of undocumented, 62% of the recently incarcerated, and 51% of the homeless, and fewer than 50% of people who are currently out-of-care have a history of taking medications to treat their HIV.
- Thirty-nine percent of PLWH/A report never skipping their medications, and at the other extreme, seven percent have stopped taking their medicines.
- Among gender groups, transgender PLWH/A are far more likely to have stopped taking their medications (31%) than either males (6%) or females (13%).
- Latinos adhere substantially more than other ethnic populations.
- Persons 24 years old or younger have a very high rate of stopping medications (20%) compared to all PLWH/A.
- Among all groups, forgetting to take them (69%) is typically the major reason for skipping medication, with Asian/Pacific Islanders (83%), Native Americans (77%), and MSM (72%) the most likely to forget.

- The next two most common reasons cited for skipping doses were side effects of medications (44%) and the difficult medication schedules (42%).

Services

Funding Sources for HIV/AIDS Services

- Based on the 2001 Title I application, the San Francisco EMA has \$203,676,646 in public funding for HIV/AIDS care. That includes about \$38.7 million in Ryan White Title I funds, \$20.3 million in ADAP (Title II), over \$75 million in Medi-Cal and Medicare, \$45 million in local funds, and about \$9 million allocated from HOPWA.
- The largest source of funding in the system is Medi-Cal and Medicaid (combined both Federal and State contributions). Next is local funding that includes general funds, in-home support, housing, funds allocated to San Mateo and Marin counties, MOUs for various services, funds for incarcerated programs, and child welfare funds. Ryan White Title I funds account for 18% of all funds, followed by Title II funds, including ADAP.

Top Needs

Each PLWH/A who participated in the survey was asked if “you needed the service in the past year.”

- Fifty-three percent named primary care as their top need which exceeded other needs significantly. The top two most needed services are within the health care service category: 1) outpatient medical care and 2) dental care.
- Food pantry services is ranked third by PLWH/A. Food vouchers, one of the subservices within the food service category, are ranked eighth by the PLWH/A. Women report the highest need for food vouchers. Transgender PLWH/A rank food services (food pantry, food vouchers, nutritional education, and home meals) higher than men.
- Three of the top ten services are within the housing service category. Rental assistance is ranked fourth by PLWH/A, DEFA is ranked sixth, and housing information is ranked ninth.
- Case management, ranked seventh by the Council, is ranked fifth by PLWH/A.
- Taxi vouchers are ranked seventh by consumers. Women are more likely than men to report a need for taxi vouchers
- Under client advocacy, benefits counseling is ranked 10th by PLWH/A.
- Notably, the perceived need for substance abuse treatment is relatively low even though it is ranked fifth out of nine service categories by the Council. While ranked higher among IDUs, it is not near their top needs that include outpatient medical care, food pantry, rental assistance, and case management. Transgender persons report a greater need for substance abuse outpatient counseling.
- PLWH/A in general do not rank any of the mental health sub-services as a top need, while mental health is ranked fourth out of nine by the Council. Women do say they need more

interaction with peers for peer counseling. Transgender persons have a greater need for residential mental health

- Women express a need for peer advocacy and also have a greater need than men for treatment advocacy.
- Women and transgender are much more likely than men to report a need for detoxification and methadone maintenance and crisis intervention.
- Men are more likely to say they need medication reimbursement, complementary treatment, legal services, and employment assistance than women or transgender PLWH/A. They are more likely to need insurance continuation than women.
- In general, African Americans and Native Americans report higher needs for most services, including food pantry, DEFA, taxi vouchers, food vouchers, housing information, peer counseling, psychological assessment, van transportation, money management, outpatient substance abuse treatment, supportive housing, residential substance abuse treatment, and detoxification/methadone maintenance.
- Latinos typically report the lowest need for services with the sole exception of reporting they need more health education and risk reduction information. In surveys of this type Latinos often indicate a lower need for services, and this is likely to be due to lower expectations and the perception of lack of eligibility.
- APIs report a greater need than other ethnic groups for dental care, case management, benefits counseling, treatment advocacy, and insurance continuation.
- Anglos are more likely to report needing complementary care (along with Native Americans), legal services, psychological assessment (along with African Americans), consumer advocacy, employment assistance, and adult day care.
- Undocumented PLWH/A report higher than average needs for peer counseling, outpatient substance abuse counseling, supportive housing, residential mental health services, and residential substance abuse counseling.
- Recently incarcerated PLWH/A report higher than average needs for several services including: food pantry, case management, DEFA, taxi vouchers, food vouchers, housing information services, treatment advocacy, van transportation, home delivered meals, supportive housing, detox and methadone maintenance, and residential substance abuse counseling.
- Homeless PLWH/A indicate greater than average need for DEFA, housing information services, treatment advocate, outpatient substance abuse counseling, detox and methadone maintenance, and residential substance abuse counseling.
- Those at a later stage of infection tend to report a greater need for basic services, including food pantry, food vouchers, DEFA, money management, and home delivered meals.

Asking For and Receiving Services

Participants in the survey were instructed to indicate whether they had asked for each of the 35 services in the past year, and whether they received the service:

- With the exception of outpatient medical care, perceived need is higher than either the reported demand or utilization for each service.
- The demand for services, however, follows reported need, with the exception of food vouchers, where PLWH/A are considerably less likely to ask for them than other top ranked services.
- Demand is also usually greater than utilization, with the exception of outpatient medical care and health education and risk reduction.
- The difference in the rank order of utilization and need reflects the much lower utilization of housing services, including rental assistance, DEFA, and housing information. There is also low utilization of food vouchers relative to the high reported need for food vouchers.
- While over 20% of the populations report currently using crystal meth, crack/cocaine, or heroin use, substance abuse services, including outpatient and residential substance treatment, is used by well under 20% of PLWH/A.
- While about 20% of the PLWH/A report significant adherence problems (skipping medication more than twice a month or stopping medications), the demand and utilization of adherence support is under 8% of PLWH/A.

Gaps

- The overall message is that unmet need and unmet demand is small. With the exception of the large unmet need for food vouchers, other gaps are under 15%.
- Outpatient medical care shows that there is no unmet demand; in fact more people receive the service than ask for it. The likely explanation is that most PLWH/A don't ask for the service; rather appointments are set. That would mean that more people receive services than "ask" for them. There is, however, an unmet need with over 10% of PLWH/A saying they need it, but not asking for it. This could reflect several things. As suggested in the out-of-care section, reasons for not asking for care were discussed in focus groups and include substance abuse issues, problems with confidentiality, access, and perceived lack of service for specific subpopulations.
- The service with the greatest unmet demand is housing. Thirteen percent of PLWH/A ask for, but did not receive housing information. Ten percent asked for but did not receive rental assistance, 8% asked for but did not receive DEFA, and 7% asked for but did not receive supportive housing. Rental assistance also had a relatively high unmet need, but other housing services had a lower unmet need. This suggests that housing is high on the agenda of PLWH/A and they ask for it when they perceive they need it. As is clear by the survey and focus group responses, however, the demand for housing far exceeds the systems capacity to provide it.
- Dental and peer advocacy are the other two services with a demand gap above 5% suggesting that, when PLWH/A ask for services they report not receiving it.
- Dental care is in the top five unmet needs. This may reflect the realization of many PLWH/A that services do not cover some dental needs or that they have used their allocation of

services. It may also reflect difficulty in obtaining appointments or traveling to the dental clinic.

- Taxi and van vouchers show an unmet need of greater than 5% suggesting that, based on focus groups, consumers find the system difficult to use or unresponsive to their needs.
- Other services with a difference of more than 5% between needing and asking for the service, include: case management, legal, psychiatric assessment, employment assistance, treatment advocacy, nutritional education, food pantry, van transportation, consumer advocacy, money management, and complementary care.

Barriers

PLWH/A were asked to rank problems on a scale ranging from “not a problem” to a “very big problem”. They ranked thirty potential problems, which can be classified into the more general categories of “organizational”, “structural, or “individual” barriers.

Problems Faced

- Structural barriers refer to “rules and regulations” and levels of access. On average, more than half the PLWH/A are likely to have a problem with these types of barriers.
- Among structural barriers, over 50% of PLWH/A have some problem with waiting for appointments, navigating the system, and red tape. Between 40% and 50% have a problem with eligibility, insurance, and cost.
- Among structural rules and regulation barriers, none were ranked as a big barrier. Yet, for those naming cost and red tape, on average, these represented moderate barriers.
- Structural “access” barriers have to do with lack of transportation, access to specialists, or lack of family-oriented services. These are mentioned much less frequently than “rules and regulations” with less than 30% of PLWH/A registering that they had a problem with these types of barriers.
- Although more PLWH/A say waiting for an appointment and navigating the system are a problem than other barriers, PLWH/A say they are small to moderate barriers.
- Organizational barriers refer to provider sensitivity and provider expertise. On average, about 40% of PLWH/A note that they have experienced these types of barriers.
- Among organizational barriers, sensitivity of the organization and feeling like a number are reported by over 50% of PLWH/A. Among those naming these barriers, it is considered a moderate barrier.
- Lack of provider expertise and provider referrals are named by over 50% of PLWH/A. However, among those reporting these barriers, they say they are small to moderate barriers.
- Forty percent of PLWH/A named discrimination as a barrier and rank it as a relatively high barrier.
- Not knowing treatment and not knowing the location of providers were named as barriers by over 60% of PLWH/A. Not knowing treatments is perceived of as a moderate barrier, while not knowing locations is viewed as a small to moderate barrier.

- Individual barriers refer to the individual's knowledge and well-being. Like "rules and regulation" barriers, on average about half the PLWH/A mention knowledge and well-being barriers. Over 50% of PLWH/A name not knowing who to ask, their own state of mind, and their own physical health as barriers. They are ranked as small to moderate barriers.

Severity of a Problem

Although the highest average barrier was rated as a moderate barrier, different populations reported considerably higher barriers.

- Overall, transgender PLWH/A report significantly higher barriers than average for most of the 30 problems they ranked. The exception were that transgender PLWH/A tend to be in less denial than other PLWH/A, they are less likely to feel like a number, and do not have greater barriers related to cost than other PLWH/A.
- The most significant barriers for males are not knowing what service is available, followed by provider sensitivity to issues, and discrimination. The highest barriers for females are different and include red tape, waiting for an appointment, no transportation, and not knowing what services they need to treat their HIV infection.
- Females report greater problems than males with their physical health, state-of-mind, understanding instruction, not getting along with their providers, communicating with providers, getting bad referrals from providers, finding specialists, fear of losing confidentiality, no childcare, and lack of or inadequate insurance.
- Among the risk groups, IDUs report higher barriers than other groups. Their highest barrier is transportation, which they rank as a moderate to large problem. They are more likely to name red tape, being treated like a number, and not accessing specialists as a barrier than other risk groups.
- Heterosexuals also cite transportation as one of their highest barriers. They are more likely than other risk groups to report their own physical health, not knowing what medical services are available, red tape (along with IDUs), and rules and regulations as barriers.
- MSM tend to rank barriers lowest among the risk groups with the exception of discrimination by providers, which they rank as a moderate barrier.
- MSM/IDU rate most barriers as quite low, but are more likely to say that they have been denied or have been afraid to seek services due to a criminal justice matter, and along with IDUs are more afraid than other risk groups of being reported to authorities.
- African American populations rate most barriers higher than other risk groups. Among top barriers, they are more likely to say they don't know where to go for services than other ethnic populations. Also, African Americans are more likely than other ethnic populations to say they face the barriers of transportation, lack of confidentiality, ability to communicate with their provider, and denial of services due to criminal justice history.
- Latinos are more likely than other risk groups to report higher barriers related to fear of being reported to authorities, lack of insurance coverage, and red tape. They are also more likely to note communication problems and that rules and regulations are problems for them in obtaining care.

- APIs say that lack of insurance coverage is a moderate to big problem, and say that cost of services is a moderate problem. They also cite a lack of childcare as a relatively high barrier. Along with Latinos, they say that getting along with providers is more a problem for them than for Anglos or African Americans.
- Native Americans rank feeling like a number and denial of services based on their criminal justice history as their top barriers. They are more likely than other ethnic populations to give a higher barrier score to their own physical health, expertise of providers, lack of helpfulness by providers, navigating the system, and lack of specialists.
- Those out-of-care between six months and one year say that not knowing who to ask for help and feeling like a number are moderate to big barriers for them. They also are more likely to say that sensitivity to their issues and denial are barriers for them.
- For the few PLWH/A who reported being out-of-care for a year or more, lack of insurance and cost of the service, not knowing the service was available, and lack of confidentiality are the main barriers cited.
- Symptomatic PLWH/A reported higher barriers than asymptomatic persons. Symptomatic PLWA reported moderate to big barriers for their own physical health and were more likely to say denial was a barrier to receiving care.

Overall Assessment

With close to \$220 million dollars available to fund the continuum of care in the San Francisco EMA, the services provided meet the medical and social service needs of the vast majority of PLWH/A. Outcomes in terms of mortality and physical and emotional health show the continuum of care is affordable, available, and accessible for most PLWH/A.

Outpatient care, the top ranked service by the Council and every subpopulation is accessed by most persons eligible who know they are HIV positive. Once in the system, access to outpatient care becomes routine and most persons don't need to ask for it. There is a small perceived need gap for outpatient care, and that is likely to reflect a number of PLWH/A who perceive they have no access and therefore don't ask for it. Based on the epidemiology and utilization figures there may be 12% - 13% who are out-of-care. One plausible group are those that fall into a crack where they are insured or make sufficient income to disqualify from assistance, but don't make enough to obtain quality care. Another subpopulation are active drug addicts who may say they need the service, but their drug use or other things keep them from asking.

Housing is the one service that has a high demand, unmet perceived need, and unmet demand. The large waiting list for housing is good indication that there is greater demand than capacity. The unmet need cuts across all subpopulations. Housing Service needs are highest among women (49%), African Americans (56%), Native Americans (54%), IDUs (58%), and undocumented PLWH/A (51%). The size of the gap in housing services that Ryan White should fill is difficult to calculate given the broad system-wide eligibility criteria. Certainly the low income and high incidence of unstable housing among PLWH/A justifies the level of demand. However, the confusing array of housing services, lack of coordination, and poor data on housing make estimating the gap impossible. Clearly more streamlined and coordinated housing services welcomed by PLWH/A, and more consistent data collection would be make planning possible in the area of housing services.

Dental care is another service that crosses all subpopulations. It has a very large eligibility gap, and over 50% of those who are eligible do not report accessing the service. Dental care has the second highest perceived need, and has one of the largest need and demand gaps. Because dental care is often not covered by any other source, even among those with insurance, demand is likely to be high. One option currently being implemented is limiting access. Current restrictions on dental care at the provider level clearly mean that those perceiving they need the care don't often get it. An alternative that may be useful is increasing capacity and using the contact with dental providers to link PLWH/A to other services such as case management, adherence, secondary prevention, and information services.

Other services needs are defined by the demographics of subpopulations, and the San Francisco EMA is facing at least two simultaneous epidemics with different needs and consumer profiles. One is a maturing epidemic populated by gay, largely Anglo men who have a relatively stable, but serious and chronic condition that requires extensive medical monitoring and adherence to an often difficult medical regime that has toxic side effects. Still, these men tend to have more traditional, insurance-reimbursed access to care and to have their medical care reimbursed by

non-Ryan White CARE funds. They tend to have attained higher level of education and as long-term survivors have a better understanding of the system and have learned to be astute self-advocates.

The challenges facing them are housing, secondary prevention, particularly related to party drug use, adherence, moving from disability to work, and financial management. Moving a once disabled individual back to work is a challenge that requires legislative initiatives to assure continuity of care, awareness of the person living with AIDS, and training for case managers and benefit counselors.

Another challenge is making sure that there is the necessary training and capacity among private physicians and clinics. Already they are being used more to provide care among those that can afford it or have access to non-Ryan White reimbursement.

The second epidemic is among populations that are more recently infected and have serious co-morbidities with their HIV infection. The homeless or those in fear of losing their housing often do not have consistent care. Anecdotal evidence strongly suggests that homelessness goes hand in hand in unstable medical care, lack of adherence, and poor health outcomes.

Many of the newly infected come to the epidemic with emotional problems or serious mental illness. That is, in turn, often related to substance abuse. Strong links to mental health programs and substance abuse programs could improve options and access to care for those needing drug abuse or mental health services. The fact that many of those with substance abuse issues do not perceive a problem also indicates the need for greater and more persuasive outreach. There is a larger need gap than demand gap for psychiatric assessment, suggesting that there are barriers to asking for mental health services.

The parallel STD infection, particularly hepatitis C – which disproportionately affects women infected with HIV – must continue to be addressed. Links to STD programs, drug programs, and awareness program are essential. Providers might be targeted to increase their awareness of the consequences of hepatitis C and HIV.

Food is a basic concern among this population that tends to be overwhelmingly poor. Their largest need gap is food vouchers, indicating a basic need that most know they will not get and therefore don't ask to receive it. Nutritional education is not perceived of as a link to improved nutritional maintenance and is a service that could be enhanced to better serve the needs of PLWH/A. As for many other services, the broad system-wide eligibility criteria makes the service gaps larger than they may be. They also tend to raise expectations for food services that are beyond the capacity of the Ryan White Care funds to provide.

While poor gay men of color are most likely to be in this population, women and heterosexuals are disproportionately represented and they have asked for specific services. Women are likely to be caregivers for their children or partners – some of whom are infected. The lack of childcare represents a barrier for these women.

As new persons enter the system there is a continued demand for case management. This category, with its peer advocacy, HERR and, sometimes, treatment advocacy appears to be confusing to both providers and PLWH/A. In focus groups, we hear often that case managers act more as gatekeepers to services rather than facilitating care. There is need to set standards, establish consumer expectations, and assure that case managers are trained to provide the appropriate linkages. Greater sensitivity to the lifestyles of a wide spectrum of clients is necessary for case management to provide adequate services.

By recognizing these two epidemics, the Council can better establish priorities and allocations. In addition, to better estimate services gaps and barriers, the system should have a mechanism to measure capacity of services in the continuum of care and create system-wide measurable and meaningful eligibility criteria. There is a separate document with recommendations for establishing a continuous data collection system for needs assessment that will build an infrastructure that will allow more precise measures of unmet need and barriers.

An Assessment of the Integrated Services Provider (ISP) Model: Needs and Recommendations

March 15, 2002 (Revised)

*A Report Delivered to the San Francisco Department of Health, HIV Health Services
Office and the Ryan White CARE Planning Council.*

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Introduction

Integrated Service Providers (ISPs) have improved the quality of life for many of San Francisco's neediest residents. HIV services are better coordinated and more clients are obtaining primary care. However, mental health, substance abuse/dependence, and insufficient multilingual services continue to pose significant barriers to optimizing the primary care that the ISPs offer. These factors are complex, multifaceted, and interrelated. This report attempts to shed some light on the issues, offer solutions, and challenge the HIV services community to re-think some of the essential service components of the ISPs.

During the data collection for this assessment, the San Francisco AIDS services community learned of significant and unexpected cuts in Ryan White CARE funding. While this development casts a shadow over this report and over the HIV/AIDS community generally, it should not distract from the main message: that resources to help meet the mental health and substance dependency needs of San Francisco's poorest residents are essential to optimize the ISP model.

Background

In 1998, the Ryan White CARE Planning Council and the San Francisco Department of Public Health (DPH) developed and implemented a multi-year plan to reorganize the system of HIV care in San Francisco based on the results of an intensive review of all services funded through Title I of the Ryan White CARE Act. The ISP program was designed to offer multidisciplinary, on-site, and/or mobile integrated services targeted to those populations in most severe need, to expand access to primary care, and to increase the efficiency of existing services. Populations in most severe need were defined as multiply diagnosed individuals, individuals who are currently outside the system of care or receiving suboptimal treatment, very low income individuals or families, and the homeless or marginally housed.

The San Francisco Department of Public Health's request for proposals (RFP) required that the following services be part of the integrated model of care and be offered to clients as needed and appropriate:

- Primary medical care;
- Housing (emergency vouchers and shallow rent subsidies);
- Case management;
- Peer advocacy;
- Treatment advocacy;
- Psychiatric consultation; and
- Vouchers for transportation, clothing and household goods.

The ISP model aims to provide a range of services in a way that is integrated or seamless from the client's perspective. Ideally, this means:

- Clients receive many services in one place or in nearby locations.
- Clients have a case manager who does a single intake and assessment and coordinates care from the various providers.
- ISP providers work as multidisciplinary teams to create and implement a comprehensive, individualized service plan for each client. The members of the multidisciplinary team meet regularly for case conferences at which they formulate client service plans, problem solve regarding

difficult service issues, and communicate pertinent information about clients, treatment modalities and community resources.

This report assesses service needs at the seven ISPs and the Circle of Care. Each service model is unique and caters to specific client subpopulations that are defined by cultural identity, gender, geographic location and/or service preference. The organizations studied are:

- **Tenderloin Care – Tenderloin AIDS Resource Center (TLC-TARC)**, a collaboration of TARC, University of California San Francisco Positive Health Practice at San Francisco General Hospital (PHP), and Forensic AIDS Project (FAP)
- **Tenderloin Care – Continuum (TLC-Continuum)**, a collaboration of Continuum, Asian and Pacific Islander Wellness Center, and Tom Waddell Health Center (Tom Waddell)
- **Women's Integrated Delivery System (WIDS)**, a collaboration between Lyon-Martin Women's Health Services and PHP, including Ward 86 and Bay Area Perinatal AIDS Center (BAPAC)
- **Asian and Pacific Islander Wellness Center (A&PIWC)**, a collaboration between A&PIWC and Tom Waddell
- **St. Mary's Medical Center**, a collaboration between St. Mary's Medical Center and Shanti
- **Native American Health Center**
- **Haight Ashbury Free Clinics**
- **Circle of Care**, a collaboration between Black Coalition on AIDS (BCA), Instituto Familiar de la Raza (IFR) and Shanti (Circle of Care is not officially an ISP because it does not offer primary care).

Scope of ISP Assessment

DPH and the Ryan White CARE Planning Council engaged CompassPoint Nonprofit Services to assess service gaps in the ISPs and to make recommendations about the feasibility of and potential methodology for expanding the services offered by the ISPs. Specifically, DPH and the Planning Council requested that CompassPoint focus its assessment on needs related to mental health, substance abuse and monolingual (non-English speaking) clients. CompassPoint was also asked to assess service gaps for persons with sight and hearing impairments.

Methodology

Data collection for this project took approximately five weeks and included 27 interviews and 5 confidential client focus groups. The research team obtained information from administrators and direct service providers from the ISP collaborating agencies, Ryan White ISP consumers, DPH staff, CARE Council members and staff, CompassPoint consultants who had provided technical assistance to the ISPs, and staff of selected community based agencies identified as important resources and potential service partners.

Standardized interview and focus group protocols were used (see Appendix B) and detailed notes taken. A list of interviewees is attached as Appendix A. General findings represent clear themes that emerged from the data collection. Unless otherwise indicated, recommendations were drawn directly from participants' feedback.

The focus of this assessment was to further define the services that should be offered by the ISPs. Trends across the ISPs were of greater importance than information about the individual ISPs. Therefore, while

the report provides insights into many of the particular issues and concerns of the individual ISPs, it should not be regarded as a report on or evaluation of the ISPs as a whole or of their member agencies. .

ISP Successes

Interviewees identified two important, positive outcomes of the ISPs:

ISPs have increased the number of people receiving primary care.

The general impression of ISP and non-ISP HIV/AIDS service providers is that the ISPs have been successful in expanding access to primary care to those populations in most severe need. As one provider put it: "The ISP is a great model. We've increased the utilization of primary care. Integrated services have helped client retention."

Staff and clients like ISPs.

ISP service providers and their clients articulated approval of the ISP model, citing the convenience of multiple services at a single location, the importance of the multidisciplinary team as a means of providing coordinated care, and the importance of a group of providers serving specific neighborhoods or target populations (such as those living in the Tenderloin, Asian and Pacific Islanders and Native Americans). Many clients and staff identified the importance of services being offered locally, "in their neighborhood," given the reluctance or inability of many to leave their neighborhood to access care.

ISP Challenges

Challenges to meeting the needs of ISP clients are varied: they are structural, they relate to resource limitations, and they relate to a lack of capacity to meet the service needs of specific populations.

Two contextual matters: First, while needs related to mental health and substance abuse are discussed here separately, many providers stressed that everyone with a substance abuse problem has an underlying mental health problem, and for this reason these issues must be examined together. This implies a need for close coordination of mental health and substance abuse services throughout the public health system.

Second, while it was out of scope for this report, one cannot discuss the needs of ISP clients without mentioning the need for housing. Many providers said that lack of stable housing was the single most important cause of chaos in their clients' lives, and for this reason the most significant barrier to obtaining and sustaining care. No service model can be truly comprehensive without attending to this basic human need.

There is a severe shortage of psychiatric and other mental health services to serve ISP clients.

Primary care providers working in the ISPs cited mental health and substance abuse issues as the greatest deterrent to clients being able to access primary care and follow through with their HIV/AIDS treatment plans. One provider went so far to say: "It is ludicrous to try to do primary care without dealing with the mental health issues. Every [mentally ill] patient that I have seen die, died due to their mental illness: they were unable to adhere to their medical regimen."

The number of hours available for psychiatric assessment and evaluation are, in general, insufficient to meet the needs of clients. Given the ISPs' target population, the paucity of available psychiatric consultation and psychiatric medication management services at certain ISP sites is striking. Ironically, TLC-TARC, which was identified by multiple service providers as serving the greatest number of severely mentally ill clients, has no psychiatric consultation services available; they do have a psychologist three hours per week who is available to do neuro-psychiatric evaluations. This provider *volunteers* his time to attend the case conferences. Other providers cited the need for more hours of psychiatric intervention – for both assessment and treatment of clients *and* to be integrated into the multidisciplinary team.

The insufficient access to psychiatric intervention has several causes. First, there appears to be an acute shortage of psychiatrists who are willing and qualified to care for clients who are homeless and have concomitant substance abuse problems and severe mental illness. Second, the funds available for psychiatric consultations in the ISP contracts have not been sufficient to meet the need. This lack of resources has meant that psychiatrists are often unavailable to participate in case conferences – which are assigned a lower priority than seeing patients – even though staff development and care planning activities are essential to ensuring coordinated care for clients with complex mental health issues. Third, working conditions are often difficult and providers that work at multiple sites must learn to function within different systems and adjust to varied service philosophies. Because the work is often part-time and under contract, psychiatrists may feel isolated spending their days traveling from agency to agency. In short, it is difficult to recruit and retain staff.

Some ISPs have successfully leveraged mental health services through Memoranda of Understanding. WIDS, for example, successfully accesses psychiatric services from AHP and therapy from New Leaf. Why has this occurred in some places but not others? Such arrangements seem to work where there is a close, collegial relationship between the providing and host agencies that focuses on making sure that clinicians' time is well spent. Mental health service providers cited multiple examples of attempting to provide services to agencies at great expense and effort only to experience no-show rates of up to 65%, lack of coordination and support for the psychiatrist or mental health professional at the site, and poor communication and follow-up. Success in the WIDS example is due to assignment of designated WIDS staff to coordinate with and support the providers and ensure that clients show up for scheduled appointments.

Some ISPs lack appropriate staff resources to handle the complex needs of those clients with severe mental illness and substance abuse/dependence.

ISP providers noted that a relatively small number of high-need clients, typically those with severe mental illness and/or substance abuse/dependence issues, require intensive case management and service intervention. This places a strain on resources and limits staff ability to provide services to other clients. Because of a lack of staff qualified to support these clients fully, the clients tend to end up in crisis. TLC/TARC staff stated that approximately three times per month they need to call the AIDS Health Project to "5150" clients in crisis. This process requires the intervention of at least one staff person, is extremely time consuming, disruptive to the program, and places an expensive and possibly avoidable burden on the mental health system. In the case of TLC-TARC, staff suggested that a single full time mental health professional could circumvent most of these crises by providing intensive, ongoing case management. Staff and clients also identified the lack of site-specific weekend coverage for clients in crisis that might reduce the need for high-cost emergency services.

Onsite site substance abuse counselors are needed.

Clients and providers identified the need for substance abuse counselors on-site to do harm reduction counseling, lead groups, make appropriate referrals, and educate and support the multidisciplinary teams. The counselors must be trained in both harm reduction and abstinence models and in mental health and

HIV issues. One provider commented that a case manager should not try to fill this function; when this was tried, the case manager tended to default to dealing with issues that seemed more pressing, like obtaining housing.

Monolingual clients face many barriers to care.

Providers and clients reported that monolingual Spanish speakers are unable to get a range of services delivered in Spanish. *According to the interviewees, there are no detox services or outpatient substance abuse services in San Francisco that are Spanish-language and culturally appropriate for Latinos.* The cost of alienation is high: “When people do go [to existing programs],” one provider said, “more than half the time they leave since they feel isolated.”

Interviewees reported that residential substance abuse treatment for Spanish speakers is in extremely short supply (one provider referred to a program that “may have” a Spanish speaker; another referred to a limited transitional housing program located in the Excelsior and funded by the County of San Mateo). Instituto Familiar de la Raza (IFR) says it needs two more Spanish-speaking psychotherapists and two substance abuse counselors to meet the current demand for its services.

Forensic AIDS Project (FAP) staff stated that services are minimal to non-existent for its Spanish-speaking clients. Support groups are all run in English, and there are no Spanish speaking mental health providers available. FAP staff said they have approached Mission Mental Health and IFR but have found these agencies without capacity to meet the demand.

Additionally, there is a clear shortage of therapy services, mental health and substance abuse/dependence services available for monolingual Asian and Pacific Islander clients. A&PIWC providers indicated that the greatest need is for speakers of Vietnamese, Thai and Lao. The next level of need is for speakers of Cantonese, Japanese and Tagalog.

A&PIWC employs a limited “Peer Leadership” program that staff said is highly effective. Multilingual clients offer practical support to other clients and help them access services. Because A&PIWC clients speak so many languages, this is an effective and important adjunct to paid staff. In addition, staff said, the program is a useful way to employ clients without compromising their benefits, to engage them more fully in the wellness model, to obtain input regarding clients’ service needs, and to meet specific language and cultural needs.

Some ISPs face challenges in meeting the needs of certain populations.

There is a general shortage of programs to meet the needs of transgendered persons. Barriers for undocumented aliens include the fear of coming into agencies to get help and lack of information about how to navigate social service systems. While developmentally disabled clients are eligible for state social services, case managers have difficulty obtaining benefits for clients since the responsible Regional Centers have overwhelming caseloads and because establishing eligibility is difficult without school records. Finally, while no providers specifically pointed to a lack of culturally appropriate services for African-Americans, both providers and clients identified the need to expand the capacity of BCA to provide a wider range of services. BCA, as a member of the Circle of Care, does not have a primary care resource as part of this collaborative. BCA also needs a treatment advocate.

Culturally competent services are critical for successful service intervention for certain populations.

While this project did not focus on unmet needs for culturally competent services, it was agreed that comments on this topic would be compiled and reported.

A variety of providers and clients commented on the importance of services culturally appropriate for Latinos, Asians and Pacific Islanders, Native Americans, and transgendered persons. According to A&PIWC providers and clients, among those mental health providers conversant in the languages of Asians and Pacific Islanders, few are comfortable with HIV/AIDS and/or gay, lesbian, bisexual or transgender issues.

One provider emphasized the importance of addressing cultural differences in program design and execution. Many monolingual Spanish speakers, for example, are reluctant to leave voicemail messages, even in response to a Spanish-language greeting. Such clients may walk away from a reception desk if no one there speaks Spanish, even if a Spanish-speaking staff member is available elsewhere. Failure to accommodate these cultural differences, this provider stressed, effectively prevents access to service.

Other Needs

Monolingual Spanish speakers, women, and emotionally fragile incarcerated persons. Imprisoned women do not have access to support groups offered to others, such as anger management, substance abuse, and stress reduction. Services for monolingual clients are poor to non-existent. FAP staff identified a critical need for access to community mental health services for bilingual/bicultural psychiatric assessment and medication management, and for licensed Spanish speaking therapists. Jail Psychiatric Services provides some of this care but is unable to meet the demand. There is also a need to provide ongoing counseling to the emotionally fragile in jail but these services are generally unavailable.

People with vision and hearing impairments. CompassPoint was asked to inquire about barriers to care for people with vision and hearing impairments. Providers cited only a few cases in which they were unable to meet a client's needs internally or by referral. Only Deaf AIDS Support Services at UCSF raised concerns, as follows: HIV-hearing loss affects up to 30% of people with AIDS and is greatly underreported; translation services are insufficient to help some deaf clients understand complex written materials; and Deaf AIDS Support Services is not sufficiently well-known, in part due to high staff turnover.

Linkages with residential substance abuse treatment providers. Lack of coordination between ISPs and substance abuse treatment providers can be an obstacle to service. One provider noted that the need to obtain signed releases to share information with residential substance abuse treatment providers was a waste of precious time. "If people have to wait," he said, "you lose clients." While most providers felt that residential substance abuse treatment providers should not be members of the ISPs, many expressed a desire for stronger linkages with such providers.

Dental care. Lyon-Martin staff stressed that oral health is increasingly important (they have seen 4-5 cases of oral cancer among crack smokers just this year). While few providers or clients suggested including dental services within the ISPs, those agencies that were able to provide dental services to their clients felt that it was a valuable adjunctive service.

Directly observed therapy for mentally ill clients. Many mentally ill clients who need psychiatric medications need directly observed therapy to attain stability. TLC-TARC staff proposed the idea of a program in which incentives such as food and activities were offered to get clients in and then provide medication assistance services. Service providers think this concept would work and be worth piloting but there is no funding.

Other services. Finally, some staff suggested that it would make sense to colocate benefits and vocational counseling and money management services with primary care, but including such services in the ISP model was not a high priority.

Structural challenges get in the way of providing seamless, integrated services.

In 1998, agencies seeking to respond to the City's RFP had only two months to create integrated service models. After the ISPs were formed, they received training on effective collaborations. While this training was valuable, some providers stated that it would have been helpful to receive this training when the collaborations began. Some providers also suggested that the rush to respond to the 1998 RFP precluded the kind of careful deliberation that should have preceded the creation of long-term working relationships.

Approximately three years after the ISPs were formed, some of the collaborations have persistent problems working together while others seem to have successfully overcome these challenges. Providers cited the following difficulties:

- *Lack of good processes for sharing client information.* Staff and client time is lost because not all the ISPs use Reggie. Primary care doctors sometimes lack access to case files and Lifetime Clinical Records (LCRs) are not available in all clinics, meaning that caregivers lack timely access to lab results and other vital data.
- *Difficulties communicating and melding philosophical differences between agencies.*
- *Lack of accountability.* The performance of one partner in the collaboration affects the others, and this is sometimes reflected in the monitoring scores. Some agencies perceive this as unfair because it can reduce their ability to raise funds for other projects.
- *Lack of clarity regarding supervision and oversight.* While the ISP staff are supposed to function as a single team, members of one agency may not have sufficient input about another agency's decision to hire shared staff. Supervision and oversight of shared staff can be tricky and must be carefully agreed upon by each of the collaborating partners.
- *Unequal pay among members of the same team.* There is often a disparity in pay for comparable jobs between the collaborating agencies' staffs. This is particularly true between City and nonprofit agency employees.

Meeting the Challenges

Recommendations that address the highest priority service needs follow. The section closes with recommendations to address barriers to effective multi-agency collaboration.

CHALLENGE: There is a severe shortage of psychiatric and other mental health services to serve ISP clients.

RESPONSE: Increase resources and use the support of mobile professionals.

Increase available funding to provide more units of service at a reimbursement rate high enough to attract qualified staff. Also encourage psychiatrists-in-training to work in nonprofits. Further assessment is needed to determine the additional funds required and to elucidate the specific psychiatric needs of each ISP.

Use mobile teams. Mobile teams – “circuit riding” professionals that travel from agency to agency – allow members of the ISP to share full-time staff, avoiding the difficulty of individual agencies needing to contract with providers for just a few hours at a time. A first approach might be to pilot test a mobile team made up of a psychiatrist, a mid-level clinician to provide counseling and therapy services, and a substance abuse counselor. The following guidelines will improve the likelihood of success:

- Each host agency should have a designated staff person who will ensure that the visiting clinicians' time is well used (minimize no-shows, make sure meeting space is ready, provide other support,

etc.). This is particularly important because of the high cost of mental health providers' time and travel.

- Standardize procedures to make it as easy as possible for the team to operate within several different systems.
- The members of the team should be salaried staff members of an organization; they need a "home base" to prevent isolation.
- The visiting professionals must be funded at a sufficient level to permit them to see patients, conduct evaluations, participate in case conferences with the larger team, and provide training and mentoring to members of the multidisciplinary team.
- Flexibility should be built into the model so that, time permitting, members of the team can respond to crisis calls from any of the ISP partners, rather than serving only clients at the agency where they are scheduled.
- Shared staff should have treatment philosophies that are not so rigid as to be incompatible with the different treatment philosophies they may encounter at each ISP.

CHALLENGE: Some ISPs lack appropriate resources to handle clients with severe mental illness and substance abuse/dependence issues.

RESPONSE: Expand capacity to handle crises and to manage these high-need clients.

- Provide funding for an appropriately trained and licensed clinician with mental health and substance abuse experience on-site, full-time, at each ISP. This position plays a key role in supporting the entire team and can provide the intensive case management and support needed to stabilize those clients with the most complex mental health needs. Supporting and stabilizing the high-need clients would reduce the stress on other members of the service team and decrease utilization of high cost crisis and emergency services.
- Support ongoing education and training for all staff – and particularly primary care providers and case managers – in mental health and substance abuse issues (such as the Harm Reduction Institute's training in "motivational interviewing"). One provider recommended including on-site case conferencing as part of the training. This provider also suggested providing training to several ISP groups simultaneously. This would conserve resources, help the ISP providers get to know each other better, and provide a venue for exchanging valuable service information.
- Explore the creation of crisis coverage services for nights and weekends for each ISP. Such intervention could reduce the use of high-cost emergency and crisis intervention services.
- Explore an expansion of drop-in services.

AHP is currently studying the need for "intensive case management" as an approach to meeting the needs of high-need clients. AHP's research has identified more than 100 CARE funded patients who utilized "high acuity" services three or more times each during calendar year 2000. The intensive case management model includes spending more time to make sure that clients get into programs and are taking their medications. According to AHP, assertive case management improves these clients' lives and frees up resources that can be used elsewhere. This model may be a useful component of an enhanced ISP program and was identified as a needed service for the TLC-TARC ISP. Perhaps Community Mental Health Services or other agency could provide a licensed mental health provider to support high-need patients at TLC-TARC.

Finally, several providers and clients spoke favorably about the Bridge Project, a \$5 million, five-year demonstration project to provide integrated services to residents of SRO hotels. Extensive evaluation materials have been created that may provide useful insights for further developing the ISP model.

CHALLENGE: On-site substance abuse counselors are needed.

RESPONSE: Expand the ISP model to include on-site substance abuse counseling.

Dedicated substance abuse counselors should provide counseling and training in harm reduction techniques (e.g., site rotation, injection site care, how to avoid overdoses, etc.) to both individuals and groups. These staff members, who must have peer-level credibility, should have training in group facilitation and in both the harm reduction and abstinence model. While agencies can share substance abuse counselors, funding must be at a high enough level to permit these personnel to participate as full members of the multidisciplinary team.

CHALLENGE: Monolingual clients face many barriers to care.

RESPONSE: Expand multilingual services both within and outside of the ISPs.

- Establish detox programs for Spanish speakers and expand residential substance abuse treatment services for Spanish speakers.
- Expand the availability of therapy services for monolingual clients particularly for speakers of Spanish, Vietnamese, Thai and Lao.
- Explore expanding A&PIWC's "Peer Leadership" program and extending it to other ISPs. In the case of A&PIWC, a \$10,000 annual line item to support Peer Leadership and to hire translators on an as needed basis would be sufficient.

CHALLENGE: Some ISPs face challenges in meeting the needs of certain populations.

- Determine what services are available for transgendered persons and evaluate their effectiveness. Expand services as needed.
- Explore expanding services available to BCA clients.
- Offer workshops presented by lawyers, health workers and others to teach undocumented aliens how to navigate the social services system. Create a basic information sheet in multiple languages describing fundamental terms (GA, SSI, DMV, etc.).
- Train mental health providers in jails about how to provide services in a way that is sensitive to the needs of persons recently diagnosed with HIV.
- Explore ways to better streamline the process of establishing benefits for HIV-positive persons who have developmental disabilities.

CHALLENGE: Culturally competent services are critical for successful service intervention for certain populations.

RESPONSE: Continue to support service providers to provide culturally competent interventions.

- Work to identify more mental health providers who speak the languages of Asians and Pacific Islanders and who are comfortable with HIV/AIDS and GLBT issues.
- Encourage and support ISPs to hire Spanish-speaking bilingual, bicultural staff, including providers and support staff who answer the phones and work in reception areas.
- Explore the need for increasing agencies' capacity to provide culturally appropriate services, particularly substance abuse treatment services, to Native Americans.

CHALLENGE: Other Needs

- Expand access of community mental health services, particularly Spanish services and ongoing counseling services, to the jail community. The authors suggest exploring whether strengthening linkages between WIDS and the jails would improve support for incarcerated women.
- Further explore the need for better information for deaf people with HIV.

- Improve linkages between ISPs and residential substance abuse providers.
- Explore inclusion of directly observed therapy for mentally ill clients. Providers noted the existence of two “Action Point” centers that provide this service and suggested exploring linkages between those centers and the ISPs.
- Explore expansion of dental services at ISPs that currently do not offer these services.
- Explore colocation of benefits counseling and money management services with primary care.

CHALLENGE: Structural challenges get in the way of providing seamless, integrated services.

RESPONSE: Invest to build the capacity of the partner agencies and to strengthen the collaboratives themselves.

Improve processes for sharing client data. Mandate the use of Reggie for ISP members, set up computers that have access to Lifetime Clinical Records (LCRs) at each primary care site, ensure that primary care providers have access to psychosocial assessments and other records, and set up confidential fax lines to enable secure communication among ISP members.

Ensure that collaboratives develop clear and precise MOUs that define the roles and responsibilities of the ISP members.

Provide funding for technical assistance in support of collaborations. “Expanding the model is a great idea,” an administrator for one of the ISP agencies said, “but not at the cost of making sure that the ISPs are working the way they should be.” If the collaborations are to be expanded by adding new services or agencies, technical assistance should be provided to help the agencies involved think deeply about what will be needed to succeed, both *before* they become committed to new collaborations and *in the transition* to creating the new service/agency configurations. Specifically, collaboratives should receive support to develop clearly defined MOUs, inter-agency communication protocols, and policies and procedures relating to staff supervision, service quality, and other aspects of the coordinated activity. Funds from private foundations may be available to fund technical assistance in support of the collaborations and to facilitate cross-ISP communication.

Establish mandated regularly scheduled meetings for mid-level service providers. The authors of this report believe that it would be productive to establish regular meetings of program staff across the ISPs. Such meetings have been effective for other groups of providers to promote problem solving, sharing information, procuring funding, establishing program niches and appropriate referral mechanisms, and general programmatic support. Some ISP providers supported this notion providing that the meetings had sound leadership and were productive.

Provide technical assistance to strengthen members of the collaboratives, and discuss further how members of collaboratives are evaluated. Collaborations work best when the partners are as equal as possible. If one partner is not meeting its obligations, the collaboration is compromised. It therefore makes sense to ensure that all members of ISPs have access to technical assistance to expand their capacity to perform within the collaboration. Additionally, DPH and providers should engage in further dialog to address providers’ concerns about how they are evaluated.

Improved coordination and communication between major branches of the Department of Public Health.

Several providers identified the desire and need for improved communication and coordination of services between the different branches of DPH. Specifically, providers articulated the need for Community Mental Health Services and Community Substance Abuse Services to better coordinate their funding priorities and service interventions with the HIV Health Services Office and with HIV service providers.

Conclusion

This assessment indicates that the ISP model has significantly improved the quality of life for many of San Francisco's neediest HIV-positive residents. ISP staffs were supportive of the integrated model and clients were appreciative of the ways in which integration helped to facilitate their access to services. More specifically, we heard from several providers that the ISPs have increased the utilization of primary care. As a bottom line, nothing is more important than that.

Unfortunately, lack of access to adequate mental health, substance abuse, and multilingual and culturally competent services (not to mention housing) are still overwhelming barriers to people in need of primary care. As one provider put it: "It's a sad situation. Clients are getting fabulous HIV care but their mental health situation is so bad they can't take advantage of it."

This, of course, isn't news. The community of providers has long known that dually or triply diagnosed clients, especially if homeless, can have enormous difficulty entering and staying in the system of care. The question here is whether expanding the ISP model to include mental health, substance abuse and additional multilingual services would help these clients.

The answer is a resounding yes. Ideally, each ISP would have sufficient and appropriately trained mental health professionals, including the assessment and treatment services of a psychiatrist, and would have a substance abuse counselor on-site. Additional services for monolingual Spanish-speaking clients would be added to an existing ISP or a new ISP focusing on the Latino community would be formed. API Wellness Center would have expanded capacity to serve its monolingual clients. All incarcerated individuals, including women and monolingual individuals, would have sufficient mental health and substance abuse/dependence support to overcome the cycle of illness and incarceration. Native Americans and African Americans affected by HIV and concurrent mental illness and substance dependence would have services appropriate to their cultural norms. And this addresses only some of the highest priority needs.

Unfortunately, we do not live in an ideal world. The recent decrease in CARE funding and the dire outlook for additional CARE dollars in the future challenges the public health community at large to examine how well San Francisco coordinates mental health and substance abuse services and funding within HIV-affected communities. Gone are the days of adequate HIV/AIDS funding to support the needs of HIV infected individuals. Augmentation of services by mental health and substance abuse specialists and agencies within the general community is necessary to support the highest need HIV-infected individuals.

This assessment is hopeful about the potential to overcome major barriers to care. Perhaps some services could be added directly to the ISPs. Perhaps stronger linkages could be specified in contracts and guaranteed through MOUs. In any case, it is incumbent on the Ryan White Planning Council, the San Francisco Department of Public Health, and the providers themselves to face these challenges and to develop viable solutions. Given the heroic history of HIV care over the last 20 years, there is no reason to doubt the possibility of success.

Appendix A - Interviews

Organization

AIDS Health Project

API Wellness Center

Black Coalition on AIDS

CompassPoint Nonprofit Services

Continuum

Forensic Aids Project

Haight-Ashbury Clinic

HIV AIDS Provider Network

HIV Consumer Rights Advocacy Project

Instituto Familiar de la Raza

Lyon-Martin Women's Health Services

Native American Health

New Leaf

HIV Planning Council

Rose Resnick Lighthouse for the Blind
and Visually Impaired

Saint Mary's Medical Center

San Francisco Department of Public
Health/HIV Services

San Francisco General Hospital, Ward 86

Shanti

TARC

Tom Waddell Health Center

Interviewee

Jim Dilley

Joanna Rinaldi

Lisa Loeb

Rachel Matillano

Lance Toma

Randall Flagg

Jude Kaye

Alfredo Vergara-Lobo

Frank Perez

Guy Vandenberg

Isela Gonzalez

Shoshana Hall

Kate Monico-Klein

Jim Beck

Jim Illig

Richard Bargetto

Gerardo Ramos

Naomi Prochovnick

Beth Rittenhouse

Parousha Zand

Mark Bronnenberg

Catherine Geanuracos

Jose Villarce

Eric Whitney

Elizabeth Newnam

Pippa Gordon

Andy Leas

Ernest Somers

Jude Swider

Laura Thomas

Russ Zellers

Catherine Lyons

Carmen Madriz

Kevin Burns

Tom Calvanese

Laurie Mattioli

Barry Zevin

Appendix B – Interview and Focus Group Protocols

ISP Assessment Interview Protocol

Contact Information

Interviewee:

Title:

Organization:

Telephone:

Name of interviewer:

Introduction

- The CARE Council requested this study. Findings and recommendations will be submitted to the DPH Office of HIV Services and the CARE Council.
- The purpose of this study is to identify gaps in ISP services for clients, with a focus on needs related to multilingual services, substance use, mental health and sight and hearing impairments.
- We're also interested in any other feedback on what a fully integrated model would look like.
- "Fully integrated services" could be very broad – we are looking for realistic solutions.

Questions

Service Needs and Gaps

- What are the most critical needs – both with regard to services needed and populations most in need of services – related to the following. Be specific, e.g., "crisis intervention by an on-site degreed professional", rather than "more mental health services". Specify substance abuse treatment needed (harm reduction vs. abstinence, short-term detox vs. long-term residential vs. outpatient). Also get an idea of how much of the services needed and what kind of experience or credentials are needed for the caregiver.
 - (1) substance use;
 - (2) mental health;
 - (3) language barriers (which languages?); and
 - (4) Sight or hearing impairments?
- To what extent is your ISP meeting these needs?
- If your ISP is not meeting these needs, are these needs being met somewhere else?
- If these needs are being met elsewhere:
 - (1) Where are they being met?
 - (2) Do you connect clients to these other providers, and if so, how, and is this effective?
- To what extent does a small number of clients impact your overall ability to provide service?
 - (1) Collaboration/Integration

- How is information shared among members of the team? Does everyone (including primary care providers) have access to intake and psychosocial assessment info?
- One provider said that they lack access to The Client Information System (CIS) while providing services on-site. Is this a problem?
- Are any of your clients getting services from providers outside the ISP (e.g., mental health services from AHP)? How is this working?
- Are psych meds and HIV meds dispensed at the same time and place?
- Are you seeing many clients with multiple case managers? How would you address this?
- How about integration with other sources of care in the city? Any suggestions about how to make things work more smoothly?

Possible Solutions

- What are some realistic ways of better providing needed services?
- What you think about adding mental health and substance abuse services into the ISP structure?
- Do you think it would be effective to share specialists among ISPs?
- Would it be effective for certain people to do more than one thing (e.g., case manager who can also do crisis intervention)?

Meaning of "Full Integration"

- We've been talking about expanding the ISP model in four areas. Are there other services that should be part of an integrated service model?

Other Information

- We would like to get input from clients. You know any groups we can talk with?
- Is there anything you would like to add?
- Who else should we talk to?
- May we contact you again if needed?

ISP Assessment

Focus Group Protocol

Introduction

We have been asked by the Planning Council and The San Francisco Department of Public Health to provide some recommendations about how Native American Health-care and other organizations that provide medical and social services can better meet the needs of people with HIV.

We have been asked to look at needs in four areas:

- Mental health
- Substance use
- People who don't speak English; and
- People who may have difficulty getting services because they have hearing or vision impairments.

We're here to hear from you about how well your needs are being met, where you are getting these needs met, and some suggestions about how to meet your needs better.

Before we get started, we'd like to establish some ground rules:

- Confidentiality -- don't repeat what you hear here; your comments will not be attributed to you
- Respect each other; we don't all have to agree -- were interested in hearing from people with different points of view.
- We are looking for practical ways of improving services -- things that can be done without a lot of new money.

Discussion

Substance abuse

1. Have you or someone you know needed services for addiction or substance use (substance abuse counseling/ treatment, 12 step groups, detoxification, residential treatment)?
2. If so, were you able to get those services here?
3. Did the services meet your (or your friend/family) needs?
4. Do you have any ideas on how to make those services better?

Mental health

5. Have you or someone you know needed services for mental health (psychiatrist, therapy, emotional support)?
6. If so, were you able to get those services here?
7. Did the services meet your (or your friend/family) needs?
8. Do you have any ideas on how to make those services better?

People who don't speak English

9. Do you know people who cannot get HIV care because they don't speak English?

People who may not see or hear well

10. Do you know people who cannot get HIV care because they are blind or deaf or have some other disability that makes Council into services difficult?

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

June 23, 2003
4:30 PM - 7:30 PM

DRAFT AGENDA

DOCUMENTS DEPT.

JUN 19 2003

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JUN 19 2003

- I. Call To Order** **4:30 PM**
- II. Roll Call** **4:32 PM**
- III. Review and Approval of Agenda** **4:35 PM**
- IV. Review and Approval of Minutes May 27, 2003** **4:40 PM**
- V. General Announcements** **4:45 PM**
- VI. Public Comment** **4:50 PM**
- VII. Presentation- Homebound Needs Assessment** **5:00 PM**
Michael deMayo & Mitchell Cohen
Consultants will present results of recently completed homebound needs assessment.

Public Comment on this item
- VIII. DPH AIDS Office Budget Update and RFP process** **5:30 PM**
Jimmy Loyce & Russ Zellers
Jimmy Loyce will provide a report on current city funding proposals for overall DPH Budget as wells as AIDS office budget. Russ Zellers will discuss service categories which will be put out for bid for 2004/2005 contract year and implications for prioritization.

Public Comment on this item
- IX. ADAP/ Medi-Cal Update** **5:55 PM**
Jeff Byers

Public Comment on this item
- X. Dinner Break** **6:10 PM**

XI. Minority AIDS Initiative Presentation-

6:20 PM

Laura Thomas

Presentation on programs currently funded with MAI money.

Public Comment on this item

XII. Review Report on ISP

6:35 PM

Susan Shea

Summary of findings from report prepared last year by compass point consultants. Discussion of results, regarding gaps in ISP programs and recommendations for funding changes.

Public Comment on this item

XIII. Review Results of Prioritization 2002/2003

6:45 PM

Brad Hume

Review and discussion of decisions made during previous prioritization including ranking of service categories and funding scenarios.

Public Comment on this item

XIV. New Service Category Listing

7:15 PM

Susan Shea

Review of changes adopted by the planning council in service category titles and implications for this year's prioritization

Public Comment on this item

XV. New Business

7:25 PM

XVI. Next Agenda

7:29 PM

Public comment on this item

XVII. ADJOURN

7:30 PM

Funding Scenarios Approved by the Council During 2002 Prioritization

Methodology:

Divide subcategories into three levels of priority.

The tiers are:

1-11 top tier

12-22 second tier

22-end bottom tier

Potential scenarios:

All of these scenarios are based on the following assumptions:

MAI Programs, Quality Management, and Planning Council Support are held harmless.

Allocations to San Mateo and Marin Counties are cut in the same proportion the overall grant is cut, and decisions about cuts within each county's HIV services are made at the county level.

Increased Funding

Add funding increase to top tier of priorities (top 11 subcategories).

Flat Funding

Reduce funding by 5% to bottom tier of programs, add to top tier programs.

0-5% cut

Cut up from bottom of priority list until funding cuts are accounted for (could result in elimination of 5+ subcategories).

>5% cut

Cut up from bottom of priority list until funding cuts are accounted for (could result in elimination of 5-10+ subcategories).

HIV HEALTH SERVICES SUB-CATEGORY SUMMARY SHEETS

SUBCATEGORY: PRIMARY CARE
CATEGORY: HEALTH CARE

CODE: A1

Total FY-02/03 CARE budget: \$3,198,889
Percent of category funding: 36.4%
Percent of total CARE award: 12.2%

Definition of service:

General management of acute and chronic medical conditions or prevention of such conditions through initial visit and intake, complete history and physical examination, lab tests necessary for evaluation and treatment, immunizations, follow-up visits and maintenance, appointments as indicated on the basis of clinical status, and referrals to medical specialists and mental health, substance abuse and other social services, as necessary. Services are provided by a physician, mid-level practitioner, or nurse and occur during a single visit at a hospital, clinic, shelter, home, or hospice, with visits lasting a minimum of 10 minutes. Services may include clinically integrated case management, nutritional counseling, mental health, and other support services.

Total Number of Programs in Sub-Category: 14

Program Descriptions & Target Populations:

- Primary care for HIV-positive and HIV-indeterminate children, adolescents and their families.
- Primary care and case management for women with HIV, specifically women with advanced HIV-related illness or complex medical problems that cannot be managed at other sites that target women.
- Jail transition services providing medical/nursing primary care and linkage to allow for uninterrupted medical treatment between jail and the community.
- Infusion therapy for treatment of specific HIV-related diseases with monitoring and follow up to assure continuity of care.
- Pharmaceutical services including medication refills, drug information, patient counseling, chronic disease medication management visits and appropriate drug monitoring, for patients receiving complex infusions such as chemotherapy.
- Integrated, multidisciplinary (before, during and after pregnancy) services for HIV-positive women and their at-risk children, including obstetrical and gynecological services, perinatal care for pregnant women, or pregnancy termination. For perinatally exposed children, neonatal/infant HIV testing and pediatric primary care/follow-up provided for the first 24 months of life, with referrals for HIV-positive children to specialized pediatric treatment and care.
- Primary medical care including physical examination and laboratory assessments for HIV-positive people in all stages of the disease.
- Medical and psychiatric services to opiate and cocaine/stimulant abusers in two specific treatment programs.
- Pharmacy staff to fill prescriptions and provide medication usage counseling.

- General medical care, comprehensive health assessments, treatment, and referral to specialty, ancillary, and tertiary services as needed for people of color, recent immigrants and refugees, monolingual Spanish speakers, transgenders, the previously incarcerated, multiply diagnosed clients, very low income people, the homeless or marginally housed, those currently outside the system of care, and/or those receiving sub-optimal treatment.
- Comprehensive outpatient primary care services including medical care, psychosocial assessment and support, urgent care, nurse telephone triage, nutritional assessment and counseling, pharmacy services, on call after hours physician by phone, linkages to specialty care, hospital care, and home health care to those with complex diagnoses i.e., other chronic diseases, mental illness, substance use, and homelessness; gay men, transgenders, women, and people of color.
- Laboratory analyses to detect *Mycobacterium tuberculosis* and other Mycobacteria species in high-risk clients.

Key Point of Entry: Yes

Definition of unit of service:

- Encounters
- Hours

Percentage of UOS that are primary care encounters: **59%**

Percentage other services: **41%**

Utilization review:

Item: TOTAL for A1 Sub-Category	Contracted	Provided	Percent
Units of Service	44,926	43,124	96%
Unduplicated clients	5,640	5,601	99%
Dollars	\$4,941,664	\$4,837,382	98%
Cost per UOS	\$110.00	\$112.17	102%
Cost per UDC	\$876.18	\$863.66	99%

Item: Primary Care Encounters Only	Contracted	Provided	Percent
Units of Service	26,637	25,916	97%
Unduplicated clients	4,211	4,153	99%
Dollars	\$4,004,422	\$3,950,854	99%
Cost per UOS	\$150.33	\$152.45	101%
Cost per UDC	\$950.95	\$951.33	100%

Utilization analysis:

On target.

Other Funding Sources for Title I medical providers:

- Private health insurance including HMO's;
- Medi-Cal
- Medicare
- San Francisco General Funds
- Title II (included in reports with Title I)
- Title III

- Title IV
- State Early Intervention Program (EIP)
- Indian Health Services (only available to eligible providers)

Other funding sources for primary medical care:

- Veterans & CHAMPUS (not billed by our providers, only available through VA Medical Centers)
- Kaiser Permanente and other private HMO's

Issues and trends:

- Decreasing reimbursements, especially Medi-Cal
- Increasing cost of providing medical care
- Increasing medical complexity of clients – more co-morbidity factors
- Some clients not eligible for Medi-Cal due to disability or immigration status
- Standards of care have been completed but not yet implemented.

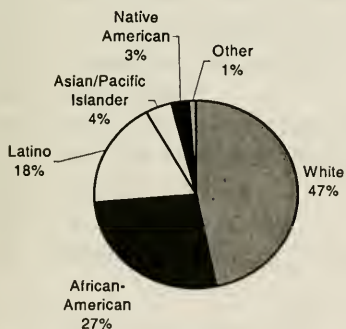
Possible Impact of Cuts:

- Fewer clients will be served
- Shorter medical visits, less time for providers to talk to and educate patients
- Wait lists, longer wait times for appointments
- May discourage access to or maintenance of care
- Less comprehensive services will be available to clients
- May have to restrict eligibility requirements
- May affect quality of care provided

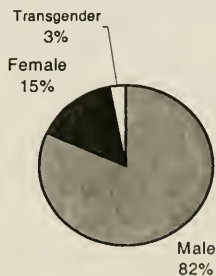
Client demographics:

Data from Reggie for 2001. Unduplicated clients by race and gender, for those clients for whom we have that information. N = 3,923.

Percent of UDC by Race



Percent of UDC by Gender



Sub-Categories in Priority Order for FY 2003

- 1. Primary Care**
- 2. Emergency Housing***
- 3. Food Bank/Home Delivered Meals**
- 4. Integrated Service Programs (ISP)**
- 5. Residential Programs and Subsidies**
- 6. Benefits Counseling**
- 7. Outpatient Mental Health & Psychiatric Consultation (Mental Health Services)**
- 8. Direct Emergency Financial Assistance***
- 9. Centralized Dental Care**
- 10. Money Management**
- 11. Transitional Housing**
- 12. Case Management**
- 13. Crisis Mental Health**
- 14. Residential Sub Abuse Treatment**
- 15. Residential Mental Health Services**
- 16. Detox**
- 17. Facility-based Home Care**
- 18. Home-based Home Care**
- 19. Outpatient Substance Abuse Services**
- 20. Legal/Immigration Assistance**
- 21. Complementary Therapies**
- 22. Integrated Case Management**
- 23. Adult Day Health Care**
- 24. Treatment Adherence**
- 25. Child Care**
- 26. Methadone Maintenance**
- 27. De-centralized Dental Care**
- 28. Transportation**
- 29. Congregate Meals**
- 30. Pharmaceuticals**

Approved by the Council, 8/26/02.

Name:

Categories	Council Member Ranking
Adult Day Health Care	
Benefits Counseling	
Case Management	
Centralized Dental Care	
Child Care	
Complementary Therapies	
Congregate Meals	
Crisis Mental Health	
De-centralized Dental Care	
Detox	
Direct Emergency Financial Assistance	
Emergency Housing	
Facility-based Home Care	
Food Bank/Home Delivered Meals	
Home-based Home Care	
Integrated Case Management	
Integrated Service Programs (ISP)	
Legal/Immigration Assistance	
Methadone Maintenance	
Money Management	
Outpatient Mental Health	
Outpatient Substance Abuse Services	
Pharmaceuticals	
Primary Care	
Psychiatric Consultation	
Rental Subsidies	
Residential Mental Health Services	
Residential Programs and Subsidies	
Residential Sub Abuse Treatment	
Transitional Housing	
Transportation	
Treatment Adherence	

Categories	Utilization	Access Point	Community Forum Ranking	NA (10-2) Importance Rank	Needs Assessment (Table 10-2)	NA (10-6) Rank	Needs Assessment (Table 10-6)	Council Member Ranking (10-24)	Cost per Unduplicated client (UDC)	Cost per Unit of Service (UDS)	Number of UDC served
Primary Care	96%	Yes	1	1	84.0%	22	-9.4%	1	\$863.66	\$112.17	5601
Emergency Housing*	100%	Yes	2*	6	49.8%	2	16.6%*	2	\$1,630.21	\$67.80	114
Integrated Service Programs (ISP)	91%	Yes	16					3	\$1,987.07	\$57.53	1381
Food Bank/home Delivered Meals	100%	Yes	5	3	59.4%	10	7.6%	4	\$1,146.39	\$1.96	1200
Residential Programs and Subsidies	99%*	Yes*	3*	4	57.3%	3	21.6%	5	6471.65*	22.86*	733*
Benefits Counseling	100%	Yes	9	7	41.5%	12	6.3%	6	\$367.48	\$63.65	760
Outpatient Mental Health	91%	Yes	20					7	\$1,490.98	\$87.81	1122
Transitional Housing	100%	Yes	6	16	12.7%	8	8.6%	8	\$10,812.00	\$89.52	30
Direct Emergency Financial Assistance*	100%	Yes	2*	6	49.8%	2	16.6%*	9	\$569.55	\$569.55	1163
Centralized Dental Care	99%	Yes	4	2	71.5%	1	16.8%*	10	\$759.72	\$91.44	707
Crisis Mental Health	97%	Yes	21	22	7.6%	17	2.6%	11	\$164.31	\$59.21	2732
Integrated Case Management	89%	Yes	15					12	\$1,404.30	\$58.21	760
Case Management	97%	Yes	11	5	56.1%	4	9.2%	13	\$350.47	\$55.26	800
Residential Mental Health Services	81%	No	17	17	12.0%	15	4.3%	14	\$6,362.04	\$104.54	75
Residential Sub Abuse Treatment	96%	Yes	14	23	7.2%	21	0.1%	15	\$8,251.06	\$112.61	449
Outpatient Substance Abuse Services	95%	Yes	19	15	16.7%	19	1.5%	16	\$608.02	\$48.46	730
Psychiatric Consultation	100%	No	25	12	27.7%	6	8.9%	17	\$635.44	\$103.32	480
Facility-based Home Care	100%	No	13	16	12.7%	8	8.6%	18	\$9,513.20	\$88.47	142
Home-based Home Care	95%	No	8	18	10.3%	16	3.1%	19	\$7,554.83	\$448.36	40
De-centralized Dental Care	26%	Yes	26	2	71.5%	1	16.8%*	20	\$329.24	\$55.47	387
Treatment Adherence	61%	Yes	27	10	28.9%	9	7.8%	21	\$983.18	\$109.78	159
Complementary Therapies	100%	No	23	9	35.1%	14	6.0%	22	\$1,370.80	\$67.75	458
Money Management	100%	No	28	14	23.4%	11	6.6%	23	\$726.60	\$29.74	770
Detox	81%	Yes	24	20	9.1%	21	0.1%	24	\$3,185.03	\$148.46	267
Legal/Immigration Assistance	91%	No	18	11	28.8%	5	9.0%	25	\$451.00	\$85.05	1038
Pharmaceuticals	18%	No	7	8	39.2%	13	6.2%	26	\$114.66	\$33.96	101
Adult Day Health Care	100%	No	12	19	9.5%	18	1.9%	27	\$3,385.89	\$150.62	75
Congregate Meals	99%	No	30					28	\$575.01	\$6.72	120
Methadone Maintenance	95%	No	29	21	9.1%	21	0.1%	29	\$2,198.99	\$89.01	176
Transportation	100%	No	10	13	25.2%	7	8.8%	30	\$356.21	\$12.61	240
Child Care	100%	No	22	24	0.7%	20	0.5%	31	\$5,801.40	\$22.96	50

Decision Matrix Interpreter

Categories – Subcategories as defined by the AO in the subcategory reports.

Utilization – Units of Service Provided/Units of Service Contracted

Access Point – Is the subcategory an entry point into the system of care.

Community Forum Ranking – The rank order as determined by the Persons Living with AIDS Advisory Committee Community Forum held on August 6. The ranking uses the number of each color sticker (3 for Green, 2 for Yellow, 1 for Red) divided by the number of votes.

NA (Needs Assessment) Importance Table 10-2 Ranking and Percentage – The rank order of the Needs Assessment Importance Table (10-2) with the higher number being more important than the smaller number.

NA (Needs Assessment) Unmet Need Table 10-6 Ranking and Percentage – The rank order of the Needs Assessment Unmet Need Table (10-6) with the higher number meaning that there is a higher number of people stating that they had an unmet need in a specific subcategory are ranked 1st.

Council Member Ranking – 24 people responded and we took the ratings and created a weighted average and ranked them accordingly.

Cost per Unduplicated Client (UDC) – These numbers were taken from the subcategory reports given to us by the AIDS Office.

Cost per Unit of Service (UOS) – These are the contracted unit of service costs.

Number of UDC Served – These are the number of unduplicated clients served by each subcategory, but it is capped at 100 percent of UDC contracted.

SHARED VALUES AND VISION

The needs and visions of clients, providers, funders, and community members of the San Francisco EMA have guided the development of a client-centered system of care for the delivery of comprehensive HIV services. The evolution of the system of care was directed by two major themes. First, in order to meet the needs of people living with HIV disease, clients of the HIV service system must be fully involved in the design, implementation and governance of the system. Second, the range of HIV services must be planned, developed, coordinated, and evaluated at the system level as parts of a unified whole. These two themes were first identified in the "1994 *Voices of Experience*" and "1994 *Comprehensive Needs Assessment*." The current system of service delivery reflects these themes. Feedback from the "1999 *Comprehensive Needs Assessment*" reiterated the desire of clients for an integrated, client-centered system of care and evaluated the progress of the current system to meet the needs of clients. The process identified the core values essential to providing an effective and meaningful client-centered system of care. These values and visions were adopted by the HIV Health Services Planning Council in May 2001.

For this plan, information and input from the Planning Council, HIV service providers, the Department of Public Health, and community members have been collected and synthesized to update the core values. Many of the values remain the same, but changes in the epidemic have highlighted two key pieces. The first change is related to the improved health of many people living with HIV/AIDS (PLWH). The importance of including people living with HIV/AIDS, particularly those who are consumers of services, in the planning and delivery of services is a central theme. As more people with HIV return to the workplace, their skills and insights continue to be needed at all levels of service delivery, planning, and evaluation, including the top levels of agency management. People with HIV/AIDS want to have a stronger sense of ownership of the system of care. Self-sufficiency and empowerment are themes that were repeated as being important, particularly by the PWA Caucus of the Planning Council.

The second change is the increasing complexity of the medical and social service needs of some clients. CARE prioritizes services for low income, uninsured and underinsured people living with HIV/AIDS. CARE clients are more likely than the overall population of people living with HIV in the EMA to be very low income, homeless, and in need of mental health and substance abuse services. The CARE-funded system focuses on those with the most severe needs and requires integration and coordination to provide accessible, quality care to those facing multiple challenges. The system has to address poverty and homelessness as barriers to care. Integration of services is central to the Planning Council and the providers' responses to the increased complexity of providing care. Services are becoming more multi-disciplinary and better coordinated to reach clients. Themes of coordination, communication, and outreach to those not in care are all present as well as an acknowledgement of the additional work needed to make the system accessible to those with severe or complex needs.

Definitions:

Client-centered: Clients, consumers, and people living with HIV/AIDS are at the center of the system as planners, providers, consumers, and evaluators. Services are planned and developed from a client-centered perspective. A client-centered perspective must govern the planning, delivery, and evaluation of services. People living with HIV/AIDS are essential at every stage of the process, including as volunteers, staff, management, and Board members of AIDS service providers. Services are ultimately evaluated by improved health outcomes for their clients and by the satisfaction of those clients.

System: This system is a network of interrelated elements. Each piece relies on the other pieces and all work together. Communication, integration, and coordination are central to the functioning of the system.

Care: Care is assistance or treatment to those in need. It includes the services needed by people living with HIV/AIDS such as health care, housing, substance abuse treatment, mental health services, and the full spectrum of support services.

Core values:

These core values shared by all of the partners in the HIV health services system guide the continued development of the comprehensive client-centered system of care. The values inform the shared vision of an ideal system of care, which in turn guides the development of the goals and objectives needed to bring the current system closer to the ideal system.

1. Access
2. Compassion and respect
3. Excellence
4. Partnership
5. Integration
6. Informed choice
7. Equity

Shared vision:

This section represents the articulation of the values into a vision of the system of care. Each of these values has multiple meanings depending on context. The meanings described here can be expanded for each service category, target population, and barrier to care. The vision component gives a short description of how the values inform an ideal system of care. This ideal system is the goal towards which the Planning Council in partnership with the Department of Public Health, the AIDS service providers, and the larger community of the EMA is striving. The values and visions described here have been articulated in a number of different forums. Most were identified in the previous planning process and updated to be more responsive to the current state of the epidemic. Some of the values were defined and elaborated upon during the Council's priority setting processes of the last few years. The PWA Caucus has added clarity and emphasis to the values and vision statement.

Value: ACCESS

Vision: The system must be accessible to all who need services. Creating equal access to all services and eliminating disparities in care are the highest priorities of the Planning Council as well as HRSA. Access incorporates both the ability of a client to find the service and feel comfortable using it and the physical availability of the service. Accessibility includes providing consumers with the information they need to know what is available. Access means welcoming new clients and reaching out to those who are not in care and bringing them in to the system. Bringing new clients in to the system must be complemented by retaining existing clients. Access must be on-going and consumers must continue to feel welcomed. Services should be available when and where people need them. Outreach efforts must focus on hard to reach, under-served, or overlooked communities of PLWH in the EMA, particularly those individuals who know that they are HIV positive but are not in care. Outreach includes one-on-one communication in easily understood language from someone to whom the recipient can relate.

The extent to which the continuum of care is accessible is often dependent on the funding for the various components. Primary care and case management are widely available. Housing, mental health care, and substance abuse treatment, however, are not adequately funded by any funding stream. The lack of housing is also acknowledged as a barrier to accessing other care. CARE resources help make some services accessible but are not ultimately enough to make all universally available. Maximizing access to insurance and entitlements for individuals, and to increased reimbursement and other funding streams for services, are both important steps toward full access to services.

Value: COMPASSION AND RESPECT

Vision: Compassion and respect are core values that should guide all human interactions. They are essential to the CARE system and inform the shared vision of an ideal system of care. Being treated with compassion and respect goes beyond individual interactions and describes an ethic of care designed to respect clients' choices, time, life decisions, cultural and ethnic identity, and current ability to address their HIV status. A continuum of care centered on compassion and respect means a system that:

- ❖ ensures that providers are well informed, well trained, and dedicated to serving the HIV community,
- ❖ treats individuals in a holistic and helpful manner,
- ❖ can serve all clients "where they are" by employing a harm reduction model of service delivery for those who need it and continuing to respect the rights of those who do not need it,
- ❖ embraces diversity by actively addressing the needs of all groups of PLWH,

- ❖ recognizes the value that employing PLWH as providers of services at all levels brings to the system,
- ❖ respects cultural diversity by providing culturally competent services,
- ❖ provides consumers with information about their rights and responsibilities, and
- ❖ respects the rights and needs of the communities in which it is based.

Value: EXCELLENCE

Vision: Excellent, high quality services are described by clients, providers, and members of the HIV Planning Council as services that:

- Meet the highest professional standards of quality
- Are comprehensive, holistic, and responsive to client needs
- Are effective at improving health status and health outcomes
- Provide the most appropriate level of care and services for the appropriate amount of time to all clients
- Are provided by trained, competent, sensitive staff
- Support clients in becoming and remaining healthy
- Address social service needs as issues that affect health status
- Engage clients in the planning, delivery, and evaluation of services
- Incorporate quality assurance and evaluation into program design

Excellence is measured through evaluation, particularly outcome measurement. The Council has encouraged the use of client-centered and client-defined outcomes in relationship to the following:

- Access to treatment and other services
- Utilization of services and adherence to care
- Quality of life or positive changes for clients
- Harm reduction goals and interventions
- Quality of services and competence of providers.

Value: PARTNERSHIP

Vision: The system of care is a partnership among funders, providers, consumers, and community members. Each member of the system has rights and responsibilities within the system and each part relies on the other parts. Trust is essential to strengthen a successful partnership. A free flow of information among all partners and a strong sense of accountability engender trust. Effective and open communication about the resources available and decision-making processes and timelines promotes active participation in the process. Decision-making should be made with input from all stakeholders including appropriate community members and groups. Accountability of each part of the system to each other part must be built in to the structure of the system. The system as a whole is also accountable to the federal government including the Health Resources & Services Administration (HRSA) and Congress and ultimately to the people of the United

States. Trust, accountability, and openness are all keys to building a system of care that feels like a partnership to those involved in it. Acknowledging the other members of the system as partners also promotes a feeling of ownership, empowerment, and inclusion.

Value: INTEGRATION

Vision: An integrated system is one in which all parts work together. There must be clear communication from one service or agency to another to promote integration and collaboration. Clients move smoothly from service to service based on their need for care. Clients are treated in a holistic and respectful manner, and are provided services that meet all of their needs. Integration includes a streamlined approach to agency intake, so clients do not have to go through repetitive forms and interviews to access multiple services. The system must be comprehensive enough to include all necessary services. Integrated services are particularly important for those people with HIV/AIDS who have multiple and complex needs, including those with severe needs as defined by the Council.

Integration reaches beyond HIV-specific services to include substance abuse, mental health and housing. In particular, HIV and STD prevention services need to be incorporated into HIV care. The Council has previously defined integration as including these components:

- Housing and primary care as centers of integrated services;
- Services that reach clients where they are, such as home based care, mobile teams, and drop-in or after-hours services; and
- Multiple services at one location, including health care, mental health, housing and substance abuse services, provided by a multi-disciplinary team of providers.

Value: INFORMED CHOICE

Vision: Information and choice are central to a number of aspects of the system of care. Clients want to have a choice of agencies, including those that are culturally or geographically specific and those that have a broader focus. Where possible, the system should provide a choice of providers and multiple options for care, reflecting the diversity of clients and communities served. Information, referral, and education about the system of care for clients, potential consumers and service providers are essential, as are cultural and linguistic competencies. As treatment regimens become more complicated, clients require reliable, comprehensive, and easily accessed information available for all levels of understanding and in culturally and linguistically competent formats. Consumers want to be trusted with the information necessary to make informed decisions about their treatment and services. Informed choice also builds a sense of

ownership on the part of people with HIV toward the system of care and helps to develop self-sufficiency and empowerment.

Value: EQUITY

Vision: Equity means dealing fairly and equally with all and not showing bias or treating individuals differently. Eliminating disparities in access to care is one of the priorities of HRSA for CARE funds and is shared by the Planning Council. Equity in access to services is essential, as is equity in treatment by staff once someone has accessed a service. Equitable access must be followed by equitable treatment. Not all consumers have the same needs for services and everyone should get those services that are appropriate for them, but for those with equal needs, the service delivery system should respond in the same respectful, compassionate, high-quality manner. Consumers should not be treated unequally based on real or perceived variations in race, ethnicity, gender, family status, sexual orientation, mode of HIV transmission, physical disability, age, immigration status, history of incarceration, substance use, mental health, or communication skills. Equal access to care is governed by multiple local, state, and federal laws and regulations, and all service providers must live up to the highest standards. Eliminating disparities and ensuring equity across the system also require challenging social and economic barriers to care such as poverty, racism, homelessness, homophobia, sexism, and anti-immigrant sentiments.

The values and visions described here serve as the foundation for the goals and objectives of the comprehensive plan for the San Francisco HIV Health Services Planning Council. The vision is that of the ideal system of care. It is the responsibility of the Council, the Department of Public Health, HIV service providers and people living with HIV/AIDS to work as partners and advocates to make it a reality. An accessible, compassionate, respectful, high quality, integrated and equitable client-centered continuum of care will improve the health status and quality of life for people living with HIV/AIDS.

An Assessment of the Integrated Services Provider (ISP) Model: Needs and Recommendations

March 15, 2002 (Revised)

*A Report Delivered to the San Francisco Department of Health, HIV Health
Services Office and the Ryan White CARE Planning Council.*

Acknowledgments

Our thanks to the many service providers and clients who shared their time with the research team, to staff of the San Francisco Department of Health, HIV Services Office, and to staff and members of the Ryan White CARE Planning Council.

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Introduction

Integrated Service Providers (ISPs) have improved the quality of life for many of San Francisco's neediest residents. HIV services are better coordinated and more clients are obtaining primary care. However, mental health, substance abuse/dependence, and insufficient multilingual services continue to pose significant barriers to optimizing the primary care that the ISPs offer. These factors are complex, multifaceted, and interrelated. This report attempts to shed some light on the issues, offer solutions, and challenge the HIV services community to re-think some of the essential service components of the ISPs.

During the data collection for this assessment, the San Francisco AIDS services community learned of significant and unexpected cuts in Ryan White CARE funding. While this development casts a shadow over this report and over the HIV/AIDS community generally, it should not distract from the main message: that resources to help meet the mental health and substance dependency needs of San Francisco's poorest residents are essential to optimize the ISP model.

Background

In 1998, the Ryan White CARE Planning Council and the San Francisco Department of Public Health (DPH) developed and implemented a multi-year plan to reorganize the system of HIV care in San Francisco based on the results of an intensive review of all services funded through Title I of the Ryan White CARE Act. The ISP program was designed to offer multidisciplinary, on-site, and/or mobile integrated services targeted to those populations in most severe need, to expand access to primary care, and to increase the efficiency of existing services. Populations in most severe need were defined as multiply diagnosed individuals, individuals who are currently outside the system of care or receiving suboptimal treatment, very low income individuals or families, and the homeless or marginally housed.

The San Francisco Department of Public Health's request for proposals (RFP) required that the following services be part of the integrated model of care and be offered to clients as needed and appropriate:

- Primary medical care;
- Housing (emergency vouchers and shallow rent subsidies);
- Case management;
- Peer advocacy;
- Treatment advocacy;
- Psychiatric consultation; and
- Vouchers for transportation, clothing and household goods.

The ISP model aims to provide a range of services in a way that is integrated or seamless from the client's perspective. Ideally, this means:

- Clients receive many services in one place or in nearby locations.
- Clients have a case manager who does a single intake and assessment and coordinates care from the various providers.
- ISP providers work as multidisciplinary teams to create and implement a comprehensive, individualized service plan for each client. The members of the multidisciplinary team meet regularly for case conferences at which they formulate client service plans, problem solve regarding difficult

service issues, and communicate pertinent information about clients, treatment modalities and community resources.

This report assesses service needs at the seven ISPs and the Circle of Care. Each service model is unique and caters to specific client subpopulations that are defined by cultural identity, gender, geographic location and/or service preference. The organizations studied are:

- **Tenderloin Care – Tenderloin AIDS Resource Center (TLC-TARC)**, a collaboration of TARC, University of California San Francisco Positive Health Practice at San Francisco General Hospital (PHP), and Forensic AIDS Project (FAP)
- **Tenderloin Care – Continuum (TLC-Continuum)**, a collaboration of Continuum, Asian and Pacific Islander Wellness Center, and Tom Waddell Health Center (Tom Waddell)
- **Women’s Integrated Delivery System (WIDS)**, a collaboration between Lyon-Martin Women’s Health Services and PHP, including Ward 86 and Bay Area Perinatal AIDS Center (BAPAC)
- **Asian and Pacific Islander Wellness Center (A&PIWC)**, a collaboration between A&PIWC and Tom Waddell
- **St. Mary’s Medical Center**, a collaboration between St. Mary’s Medical Center and Shanti
- **Native American Health Center**
- **Haight Ashbury Free Clinics**
- **Circle of Care**, a collaboration between Black Coalition on AIDS (BCA), Instituto Familiar de la Raza (IFR) and Shanti (Circle of Care is not officially an ISP because it does not offer primary care).

Scope of ISP Assessment

DPH and the Ryan White CARE Planning Council engaged CompassPoint Nonprofit Services to assess service gaps in the ISPs and to make recommendations about the feasibility of and potential methodology for expanding the services offered by the ISPs. Specifically, DPH and the Planning Council requested that CompassPoint focus its assessment on needs related to mental health, substance abuse and monolingual (non-English speaking) clients. CompassPoint was also asked to assess service gaps for persons with sight and hearing impairments.

Methodology

Data collection for this project took approximately five weeks and included 27 interviews and 5 confidential client focus groups. The research team obtained information from administrators and direct service providers from the ISP collaborating agencies, Ryan White ISP consumers, DPH staff, CARE Council members and staff, CompassPoint consultants who had provided technical assistance to the ISPs, and staff of selected community based agencies identified as important resources and potential service partners.

Standardized interview and focus group protocols were used (see Appendix B) and detailed notes taken. A list of interviewees is attached as Appendix A. General findings represent clear themes that emerged from the data collection. Unless otherwise indicated, recommendations were drawn directly from participants' feedback.

The focus of this assessment was to further define the services that should be offered by the ISPs. Trends across the ISPs were of greater importance than information about the individual ISPs. Therefore, while the

report provides insights into many of the particular issues and concerns of the individual ISPs, it should not be regarded as a report on or evaluation of the ISPs as a whole or of their member agencies.

ISP Successes

Interviewees identified two important, positive outcomes of the ISPs:

ISPs have increased the number of people receiving primary care.

The general impression of ISP and non-ISP HIV/AIDS service providers is that the ISPs have been successful in expanding access to primary care to those populations in most severe need. As one provider put it: “The ISP is a great model. We’ve increased the utilization of primary care. Integrated services have helped client retention.”

Staff and clients like ISPs.

ISP service providers and their clients articulated approval of the ISP model, citing the convenience of multiple services at a single location, the importance of the multidisciplinary team as a means of providing coordinated care, and the importance of a group of providers serving specific neighborhoods or target populations (such as those living in the Tenderloin, Asian and Pacific Islanders and Native Americans). Many clients and staff identified the importance of services being offered locally, “in their neighborhood,” given the reluctance or inability of many to leave their neighborhood to access care.

ISP Challenges

Challenges to meeting the needs of ISP clients are varied: they are structural, they relate to resource limitations, and they relate to a lack of capacity to meet the service needs of specific populations.

Two contextual matters: First, while needs related to mental health and substance abuse are discussed here separately, many providers stressed that everyone with a substance abuse problem has an underlying mental health problem, and for this reason these issues must be examined together. This implies a need for close coordination of mental health and substance abuse services throughout the public health system.

Second, while it was out of scope for this report, one cannot discuss the needs of ISP clients without mentioning the need for housing. Many providers said that lack of stable housing was the single most important cause of chaos in their clients’ lives, and for this reason the most significant barrier to obtaining and sustaining care. No service model can be truly comprehensive without attending to this basic human need.

There is a severe shortage of psychiatric and other mental health services to serve ISP clients.

Primary care providers working in the ISPs cited mental health and substance abuse issues as the greatest deterrent to clients being able to access primary care and follow through with their HIV/AIDS treatment plans. One provider went so far to say: “It is ludicrous to try to do primary care without dealing with the mental health issues. Every [mentally ill] patient that I have seen die, died due to their mental illness: they were unable to adhere to their medical regimen.”

The number of hours available for psychiatric assessment and evaluation are, in general, insufficient to meet the needs of clients. Given the ISPs' target population, the paucity of available psychiatric consultation and psychiatric medication management services at certain ISP sites is striking. Ironically, TLC-TARC, which was identified by multiple service providers as serving the greatest number of severely mentally ill clients, has no psychiatric consultation services available; they do have a psychologist three hours per week who is available to do neuro-psychiatric evaluations. This provider *volunteers* his time to attend the case conferences. Other providers cited the need for more hours of psychiatric intervention – for both assessment and treatment of clients *and* to be integrated into the multidisciplinary team.

The insufficient access to psychiatric intervention has several causes. First, there appears to be an acute shortage of psychiatrists who are willing and qualified to care for clients who are homeless and have concomitant substance abuse problems and severe mental illness. Second, the funds available for psychiatric consultations in the ISP contracts have not been sufficient to meet the need. This lack of resources has meant that psychiatrists are often unavailable to participate in case conferences -- which are assigned a lower priority than seeing patients -- even though staff development and care planning activities are essential to ensuring coordinated care for clients with complex mental health issues. Third, working conditions are often difficult and providers that work at multiple sites must learn to function within different systems and adjust to varied service philosophies. Because the work is often part-time and under contract, psychiatrists may feel isolated spending their days traveling from agency to agency. In short, it is difficult to recruit and retain staff.

Some ISPs have successfully leveraged mental health services through Memoranda of Understanding. WIDS, for example, successfully accesses psychiatric services from AHP and therapy from New Leaf. Why has this occurred in some places but not others? Such arrangements seem to work where there is a close, collegial relationship between the providing and host agencies that focuses on making sure that clinicians' time is well spent. Mental health service providers cited multiple examples of attempting to provide services to agencies at great expense and effort only to experience no-show rates of up to 65%, lack of coordination and support for the psychiatrist or mental health professional at the site, and poor communication and follow-up. Success in the WIDS example is due to assignment of designated WIDS staff to coordinate with and support the providers and ensure that clients show up for scheduled appointments.

Some ISPs lack appropriate staff resources to handle the complex needs of those clients with severe mental illness and substance abuse/dependence.

ISP providers noted that a relatively small number of high-need clients, typically those with severe mental illness and/or substance abuse/dependence issues, require intensive case management and service intervention. This places a strain on resources and limits staff ability to provide services to other clients. Because of a lack of staff qualified to support these clients fully, the clients tend to end up in crisis. TLC/TARC staff stated that approximately three times per month they need to call the AIDS Health Project to “5150” clients in crisis. This process requires the intervention of at least one staff person, is extremely time consuming, disruptive to the program, and places an expensive and possibly avoidable burden on the mental health system. In the case of TLC-TARC, staff suggested that a single full time mental health professional could circumvent most of these crises by providing intensive, ongoing case management. Staff and clients also identified the lack of site-specific weekend coverage for clients in crisis that might reduce the need for high-cost emergency services.

Onsite site substance abuse counselors are needed.

Clients and providers identified the need for substance abuse counselors on-site to do harm reduction counseling, lead groups, make appropriate referrals, and educate and support the multidisciplinary teams. The counselors must be trained in both harm reduction and abstinence models and in mental health and HIV

issues. One provider commented that a case manager should not try to fill this function; when this was tried, the case manager tended to default to dealing with issues that seemed more pressing, like obtaining housing.

Monolingual clients face many barriers to care.

Providers and clients reported that monolingual Spanish speakers are unable to get a range of services delivered in Spanish. *According to the interviewees, there are no detox services or outpatient substance abuse services in San Francisco that are Spanish-language and culturally appropriate for Latinos.* The cost of alienation is high: “When people do go [to existing programs],” one provider said, “more than half the time they leave since they feel isolated.”

Interviewees reported that residential substance abuse treatment for Spanish speakers is in extremely short supply (one provider referred to a program that “may have” a Spanish speaker; another referred to a limited transitional housing program located in the Excelsior and funded by the County of San Mateo). Instituto Familiar de la Raza (IFR) says it needs two more Spanish-speaking psychotherapists and two substance abuse counselors to meet the current demand for its services.

Forensic AIDS Project (FAP) staff stated that services are minimal to non-existent for its Spanish-speaking clients. Support groups are all run in English, and there are no Spanish speaking mental health providers available. FAP staff said they have approached Mission Mental Health and IFR but have found these agencies without capacity to meet the demand.

Additionally, there is a clear shortage of therapy services, mental health and substance abuse/dependence services available for monolingual Asian and Pacific Islander clients. A&PIWC providers indicated that the greatest need is for speakers of Vietnamese, Thai and Lao. The next level of need is for speakers of Cantonese, Japanese and Tagalog.

A&PIWC employs a limited “Peer Leadership” program that staff said is highly effective. Multilingual clients offer practical support to other clients and help them access services. Because A&PIWC clients speak so many languages, this is an effective and important adjunct to paid staff. In addition, staff said, the program is a useful way to employ clients without compromising their benefits, to engage them more fully in the wellness model, to obtain input regarding clients’ service needs, and to meet specific language and cultural needs.

Some ISPs face challenges in meeting the needs of certain populations.

There is a general shortage of programs to meet the needs of transgendered persons. Barriers for undocumented aliens include the fear of coming into agencies to get help and lack of information about how to navigate social service systems. While developmentally disabled clients are eligible for state social services, case managers have difficulty obtaining benefits for clients since the responsible Regional Centers have overwhelming caseloads and because establishing eligibility is difficult without school records. Finally, while no providers specifically pointed to a lack of culturally appropriate services for African-Americans, both providers and clients identified the need to expand the capacity of BCA to provide a wider range of services. BCA, as a member of the Circle of Care, does not have a primary care resource as part of this collaborative. BCA also needs a treatment advocate.

Culturally competent services are critical for successful service intervention for certain populations.

While this project did not focus on unmet needs for culturally competent services, it was agreed that comments on this topic would be compiled and reported.

A variety of providers and clients commented on the importance of services culturally appropriate for Latinos, Asians and Pacific Islanders, Native Americans, and transgendered persons. According to A&PIWC providers and clients, among those mental health providers conversant in the languages of Asians and Pacific Islanders, few are comfortable with HIV/AIDS and/or gay, lesbian, bisexual or transgender issues.

One provider emphasized the importance of addressing cultural differences in program design and execution. Many monolingual Spanish speakers, for example, are reluctant to leave voicemail messages, even in response to a Spanish-language greeting. Such clients may walk away from a reception desk if no one there speaks Spanish, even if a Spanish-speaking staff member is available elsewhere. Failure to accommodate these cultural differences, this provider stressed, effectively prevents access to service.

Other Needs

Monolingual Spanish speakers, women, and emotionally fragile incarcerated persons. Imprisoned women do not have access to support groups offered to others, such as anger management, substance abuse, and stress reduction. Services for monolingual clients are poor to non-existent. FAP staff identified a critical need for access to community mental health services for bilingual/bicultural psychiatric assessment and medication management, and for licensed Spanish speaking therapists. Jail Psychiatric Services provides some of this care but is unable to meet the demand. There is also a need to provide ongoing counseling to the emotionally fragile in jail but these services are generally unavailable.

People with vision and hearing impairments. CompassPoint was asked to inquire about barriers to care for people with vision and hearing impairments. Providers cited only a few cases in which they were unable to meet a client's needs internally or by referral. Only Deaf AIDS Support Services at UCSF raised concerns, as follows: HIV-hearing loss affects up to 30% of people with AIDS and is greatly underreported; translation services are insufficient to help some deaf clients understand complex written materials; and Deaf AIDS Support Services is not sufficiently well-known, in part due to high staff turnover.

Linkages with residential substance abuse treatment providers. Lack of coordination between ISPs and substance abuse treatment providers can be an obstacle to service. One provider noted that the need to obtain signed releases to share information with residential substance abuse treatment providers was a waste of precious time. "If people have to wait," he said, "you lose clients." While most providers felt that residential substance abuse treatment providers should not be members of the ISPs, many expressed a desire for stronger linkages with such providers.

Dental care. Lyon-Martin staff stressed that oral health is increasingly important (they have seen 4-5 cases of oral cancer among crack smokers just this year). While few providers or clients suggested including dental services within the ISPs, those agencies that were able to provide dental services to their clients felt that it was a valuable adjunctive service.

Directly observed therapy for mentally ill clients. Many mentally ill clients who need psychiatric medications need directly observed therapy to attain stability. TLC-TARC staff proposed the idea of a program in which incentives such as food and activities were offered to get clients in and then provide medication assistance services. Service providers think this concept would work and be worth piloting but there is no funding.

Other services. Finally, some staff suggested that it would make sense to colocate benefits and vocational counseling and money management services with primary care, but including such services in the ISP model was not a high priority.

Structural challenges get in the way of providing seamless, integrated services.

In 1998, agencies seeking to respond to the City's RFP had only two months to create integrated service models. After the ISPs were formed, they received training on effective collaborations. While this training was valuable, some providers stated that it would have been helpful to receive this training when the collaborations began. Some providers also suggested that the rush to respond to the 1998 RFP precluded the kind of careful deliberation that should have preceded the creation of long-term working relationships.

Approximately three years after the ISPs were formed, some of the collaborations have persistent problems working together while others seem to have successfully overcome these challenges. Providers cited the following difficulties:

- *Lack of good processes for sharing client information.* Staff and client time is lost because not all the ISPs use Reggie. Primary care doctors sometimes lack access to case files and Lifetime Clinical Records (LCRs) are not available in all clinics, meaning that caregivers lack timely access to lab results and other vital data.
- *Difficulties communicating and melding philosophical differences between agencies.*
- *Lack of accountability.* The performance of one partner in the collaboration affects the others, and this is sometimes reflected in the monitoring scores. Some agencies perceive this as unfair because it can reduce their ability to raise funds for other projects.
- *Lack of clarity regarding supervision and oversight.* While the ISP staff are supposed to function as a single team, members of one agency may not have sufficient input about another agency's decision to hire shared staff. Supervision and oversight of shared staff can be tricky and must be carefully agreed upon by each of the collaborating partners.
- *Unequal pay among members of the same team.* There is often a disparity in pay for comparable jobs between the collaborating agencies' staffs. This is particularly true between City and nonprofit agency employees.

Meeting the Challenges

Recommendations that address the highest priority service needs follow. The section closes with recommendations to address barriers to effective multi-agency collaboration.

CHALLENGE: There is a severe shortage of psychiatric and other mental health services to serve ISP clients.

RESPONSE: Increase resources and use the support of mobile professionals.

Increase available funding to provide more units of service at a reimbursement rate high enough to attract qualified staff. Also encourage psychiatrists-in-training to work in nonprofits. Further assessment is needed to determine the additional funds required and to elucidate the specific psychiatric needs of each ISP.

Use mobile teams. Mobile teams – “circuit riding” professionals that travel from agency to agency – allow members of the ISP to share full-time staff, avoiding the difficulty of individual agencies needing to contract with providers for just a few hours at a time. A first approach might be to pilot test a mobile team made up of a psychiatrist, a mid-level clinician to provide counseling and therapy services, and a substance abuse counselor. The following guidelines will improve the likelihood of success:

- Each host agency should have a designated staff person who will ensure that the visiting clinicians' time is well used (minimize no-shows, make sure meeting space is ready, provide other support, etc.). This is particularly important because of the high cost of mental health providers' time and travel.

- Standardize procedures to make it as easy as possible for the team to operate within several different systems.
- The members of the team should be salaried staff members of an organization; they need a “home base” to prevent isolation.
- The visiting professionals must be funded at a sufficient level to permit them to see patients, conduct evaluations, participate in case conferences with the larger team, and provide training and mentoring to members of the multidisciplinary team.
- Flexibility should be built into the model so that, time permitting, members of the team can respond to crisis calls from any of the ISP partners, rather than serving only clients at the agency where they are scheduled.
- Shared staff should have treatment philosophies that are not so rigid as to be incompatible with the different treatment philosophies they may encounter at each ISP.

CHALLENGE: Some ISPs lack appropriate resources to handle clients with severe mental illness and substance abuse/dependence issues.

RESPONSE: Expand capacity to handle crises and to manage these high-need clients.

- Provide funding for an appropriately trained and licensed clinician with mental health and substance abuse experience on-site, full-time, at each ISP. This position plays a key role in supporting the entire team and can provide the intensive case management and support needed to stabilize those clients with the most complex mental health needs. Supporting and stabilizing the high-need clients would reduce the stress on other members of the service team and decrease utilization of high cost crisis and emergency services.
- Support ongoing education and training for all staff – and particularly primary care providers and case managers -- in mental health and substance abuse issues (such as the Harm Reduction Institute’s training in “motivational interviewing”). One provider recommended including on-site case conferencing as part of the training. This provider also suggested providing training to several ISP groups simultaneously. This would conserve resources, help the ISP providers get to know each other better, and provide a venue for exchanging valuable service information.
- Explore the creation of crisis coverage services for nights and weekends for each ISP: Such intervention could reduce the use of high-cost emergency and crisis intervention services.
- Explore an expansion of drop-in services.

AHP is currently studying the need for “intensive case management” as an approach to meeting the needs of high-need clients. AHP’s research has identified more than 100 CARE funded patients who utilized “high acuity” services three or more times each during calendar year 2000. The intensive case management model includes spending more time to make sure that clients get into programs and are taking their medications. According to AHP, assertive case management improves these clients’ lives and frees up resources that can be used elsewhere. This model may be a useful component of an enhanced ISP program and was identified as a needed service for the TLC-TARC ISP. Perhaps Community Mental Health Services or other agency could provide a licensed mental health provider to support high-need patients at TLC-TARC.

Finally, several providers and clients spoke favorably about the Bridge Project, a \$5 million, five-year demonstration project to provide integrated services to residents of SRO hotels. Extensive evaluation materials have been created that may provide useful insights for further developing the ISP model.

CHALLENGE: On-site substance abuse counselors are needed.

RESPONSE: Expand the ISP model to include on-site substance abuse counseling.

Dedicated substance abuse counselors should provide counseling and training in harm reduction techniques (e.g., site rotation, injection site care, how to avoid overdoses, etc.) to both individuals and groups. These staff members, who must have peer-level credibility, should have training in group facilitation and in both the harm reduction and abstinence model. While agencies can share substance abuse counselors, funding must be at a high enough level to permit these personnel to participate as full members of the multidisciplinary team.

CHALLENGE: Monolingual clients face many barriers to care.

RESPONSE: Expand multilingual services both within and outside of the ISPs.

- Establish detox programs for Spanish speakers and expand residential substance abuse treatment services for Spanish speakers.
- Expand the availability of therapy services for monolingual clients particularly for speakers of Spanish, Vietnamese, Thai and Lao.
- Explore expanding A&PIWC's "Peer Leadership" program and extending it to other ISPs. In the case of A&PIWC, a \$10,000 annual line item to support Peer Leadership and to hire translators on an as needed basis would be sufficient.

CHALLENGE: Some ISPs face challenges in meeting the needs of certain populations.

- Determine what services are available for transgendered persons and evaluate their effectiveness. Expand services as needed.
- Explore expanding services available to BCA clients.
- Offer workshops presented by lawyers, health workers and others to teach undocumented aliens how to navigate the social services system. Create a basic information sheet in multiple languages describing fundamental terms (GA, SSI, DMV, etc.).
- Train mental health providers in jails about how to provide services in a way that is sensitive to the needs of persons recently diagnosed with HIV.
- Explore ways to better streamline the process of establishing benefits for HIV-positive persons who have developmental disabilities.

CHALLENGE: Culturally competent services are critical for successful service intervention for certain populations.

RESPONSE: Continue to support service providers to provide culturally competent interventions.

- Work to identify more mental health providers who speak the languages of Asians and Pacific Islanders and who are comfortable with HIV/AIDS and GLBT issues.
- Encourage and support ISPs to hire Spanish-speaking bilingual, bicultural staff, including providers and support staff who answer the phones and work in reception areas.
- Explore the need for increasing agencies' capacity to provide culturally appropriate services, particularly substance abuse treatment services, to Native Americans.

CHALLENGE: Other Needs

- Expand access of community mental health services, particularly Spanish services and ongoing counseling services, to the jail community. The authors suggest exploring whether strengthening linkages between WIDS and the jails would improve support for incarcerated women.
- Further explore the need for better information for deaf people with HIV.
- Improve linkages between ISPs and residential substance abuse providers.

- Explore inclusion of directly observed therapy for mentally ill clients. Providers noted the existence of two “Action Point” centers that provide this service and suggested exploring linkages between those centers and the ISPs.
- Explore expansion of dental services at ISPs that currently do not offer these services.
- Explore colocation of benefits counseling and money management services with primary care.

CHALLENGE: Structural challenges get in the way of providing seamless, integrated services.

RESPONSE: Invest to build the capacity of the partner agencies and to strengthen the collaboratives themselves.

Improve processes for sharing client data. Mandate the use of Reggie for ISP members, set up computers that have access to Lifetime Clinical Records (LCRs) at each primary care site, ensure that primary care providers have access to psychosocial assessments and other records, and set up confidential fax lines to enable secure communication among ISP members.

Ensure that collaboratives develop clear and precise MOUs that define the roles and responsibilities of the ISP members.

Provide funding for technical assistance in support of collaborations. “Expanding the model is a great idea,” an administrator for one of the ISP agencies said, “but not at the cost of making sure that the ISPs are working the way they should be.” If the collaborations are to be expanded by adding new services or agencies, technical assistance should be provided to help the agencies involved think deeply about what will be needed to succeed, both *before* they become committed to new collaborations and *in the transition* to creating the new service/agency configurations. Specifically, collaboratives should receive support to develop clearly defined MOUs, inter-agency communication protocols, and policies and procedures relating to staff supervision, service quality, and other aspects of the coordinated activity. Funds from private foundations may be available to fund technical assistance in support of the collaborations and to facilitate cross-ISP communication.

Establish mandated regularly scheduled meetings for mid-level service providers. The authors of this report believe that it would be productive to establish regular meetings of program staff across the ISPs. Such meetings have been effective for other groups of providers to promote problem solving, sharing information, procuring funding, establishing program niches and appropriate referral mechanisms, and general programmatic support. Some ISP providers supported this notion providing that the meetings had sound leadership and were productive.

Provide technical assistance to strengthen members of the collaboratives, and discuss further how members of collaboratives are evaluated. Collaborations work best when the partners are as equal as possible. If one partner is not meeting its obligations, the collaboration is compromised. It therefore makes sense to ensure that all members of ISPs have access to technical assistance to expand their capacity to perform within the collaboration. Additionally, DPH and providers should engage in further dialog to address providers’ concerns about how they are evaluated.

Improved coordination and communication between major branches of the Department of Public Health. Several providers identified the desire and need for improved communication and coordination of services between the different branches of DPH. Specifically, providers articulated the need for Community Mental Health Services and Community Substance Abuse Services to better coordinate their funding priorities and service interventions with the HIV Health Services Office and with HIV service providers.

Conclusion

This assessment indicates that the ISP model has significantly improved the quality of life for many of San Francisco's neediest HIV-positive residents. ISP staffs were supportive of the integrated model and clients were appreciative of the ways in which integration helped to facilitate their access to services. More specifically, we heard from several providers that the ISPs have increased the utilization of primary care. As a bottom line, nothing is more important than that.

Unfortunately, lack of access to adequate mental health, substance abuse, and multilingual and culturally competent services (not to mention housing) are still overwhelming barriers to people in need of primary care. As one provider put it: "It's a sad situation. Clients are getting fabulous HIV care but their mental health situation is so bad they can't take advantage of it."

This, of course, isn't news. The community of providers has long known that dually or triply diagnosed clients, especially if homeless, can have enormous difficulty entering and staying in the system of care. The question here is whether expanding the ISP model to include mental health, substance abuse and additional multilingual services would help these clients.

The answer is a resounding yes. Ideally, each ISP would have sufficient and appropriately trained mental health professionals, including the assessment and treatment services of a psychiatrist, and would have a substance abuse counselor on-site. Additional services for monolingual Spanish-speaking clients would be added to an existing ISP or a new ISP focusing on the Latino community would be formed. API Wellness Center would have expanded capacity to serve its monolingual clients. All incarcerated individuals, including women and monolingual individuals, would have sufficient mental health and substance abuse/dependence support to overcome the cycle of illness and incarceration. Native Americans and African Americans affected by HIV and concurrent mental illness and substance dependence would have services appropriate to their cultural norms. And this addresses only some of the highest priority needs.

Unfortunately, we do not live in an ideal world. The recent decrease in CARE funding and the dire outlook for additional CARE dollars in the future challenges the public health community at large to examine how well San Francisco coordinates mental health and substance abuse services and funding within HIV-affected communities. Gone are the days of adequate HIV/AIDS funding to support the needs of HIV infected individuals. Augmentation of services by mental health and substance abuse specialists and agencies within the general community is necessary to support the highest need HIV-infected individuals.

This assessment is hopeful about the potential to overcome major barriers to care. Perhaps some services could be added directly to the ISPs. Perhaps stronger linkages could be specified in contracts and guaranteed through MOUs. In any case, it is incumbent on the Ryan White Planning Council, the San Francisco Department of Public Health, and the providers themselves to face these challenges and to develop viable solutions. Given the heroic history of HIV care over the last 20 years, there is no reason to doubt the possibility of success.

Appendix A - Interviews

Organization

AIDS Health Project

API Wellness Center

Black Coalition on AIDS
CompassPoint Nonprofit Services

Continuum

Forensic Aids Project

Haight-Ashbury Clinic
HIV AIDS Provider Network
HIV Consumer Rights Advocacy Project
Instituto Familiar de la Raza
Lyon-Martin Women's Health Services

Native American Health
New Leaf
HIV Planning Council

Rose Resnick Lighthouse for the Blind
and Visually Impaired
Saint Mary's Medical Center

San Francisco Department of Public Health/HI
Services
San Francisco General Hospital, Ward 86

Shanti
TARC

Tom Waddell Health Center

Interviewee

Jim Dilley
Joanna Rinaldi
Lisa Loeb
Rachel Matillano
Lance Toma
Randall Flagg
Jude Kaye
Alfredo Vergara-Lobo
Frank Perez
Guy Vandenberg
Isela Gonzalez
Shoshana Hall
Kate Monico-Klein
Jim Beck
Jim Illig
Richard Bargetto
Gerardo Ramos
Naomi Prochovnick
Beth Rittenhouse
Parousha Zand
Mark Bronnenberg
Catherine Geanuracos
Jose Villarce
Eric Whitney
Elizabeth Newnam

Pippa Gordon
Andy Leas
Ernest Somers
Jude Swider
Laura Thomas
Russ Zellers
Catherine Lyons
Carmen Madriz
Kevin Burns
Tom Calvanese
Laurie Mattioli
Barry Zevin

Appendix B – Interview and Focus Group Protocols

ISP Assessment Interview Protocol

Contact Information

Interviewee:
Title:
Organization:
Telephone:
Name of interviewer:

Introduction

- The CARE Council requested this study. Findings and recommendations will be submitted to the DPH Office of HIV Services and the CARE Council.
- The purpose of this study is to identify gaps in ISP services for clients, with a focus on needs related to multilingual services, substance use, mental health and sight and hearing impairments.
- We're also interested in any other feedback on what a fully integrated model would look like.
- "Fully integrated services" could be very broad -- we are looking for realistic solutions.

Questions

Service Needs and Gaps

- What are the most critical needs – both with regard to services needed and populations most in need of services – related to the following. Be specific, e.g., "crisis intervention by an on-site degreed professional", rather than "more mental health services". Specify substance abuse treatment needed (harm reduction vs. abstinence, short-term detox vs. long-term residential vs. outpatient). Also get an idea of how much of the services needed and what kind of experience or credentials are needed for the caregiver.
 - (1) substance use;
 - (2) mental health;
 - (3) language barriers (which languages?); and
 - (4) Sight or hearing impairments?
- To what extent is your ISP meeting these needs?
- If your ISP is not meeting these needs, are these needs being met somewhere else?
- If these needs are being met elsewhere:
 - (1) Where are they being met?
 - (2) Do you connect clients to these other providers, and if so, how, and is this effective?
- To what extent does a small number of clients impact your overall ability to provide service?
 - (1) Collaboration/Integration

- How is information shared among members of the team? Does everyone (including primary care providers) have access to intake and psychosocial assessment info?
- One provider said that they lack access to The Client Information System (CIS) while providing services on-site. Is this a problem?
- Are any of your clients getting services from providers outside the ISP (e.g., mental health services from AHP)? How is this working?
- Are psych meds and HIV meds dispensed at the same time and place?
- Are you seeing many clients with multiple case managers? How would you address this?
- How about integration with other sources of care in the city? Any suggestions about how to make things work more smoothly?

Possible Solutions

- What are some realistic ways of better providing needed services?
- What you think about adding mental health and substance abuse services into the ISP structure?
- Do you think it would be effective to share specialists among ISPs?
- Would it be effective for certain people to do more than one thing (e.g., case manager who can also do crisis intervention)?

Meaning of “Full Integration”

- We've been talking about expanding the ISP model in four areas. Are there other services that should be part of an integrated service model?

Other Information

- We would like to get input from clients. You know any groups we can talk with?
- Is there anything you would like to add?
- Who else should we talk to?
- May we contact you again if needed?

ISP Assessment

Focus Group Protocol

Introduction

We have been asked by the Planning Council and The San Francisco Department of Public Health to provide some recommendations about how Native American Health-care and other organizations that provide medical and social services can better meet the needs of people with HIV.

We have been asked to look at needs in four areas:

- Mental health
- Substance use
- People who don't speak English; and
- People who may have difficulty getting services because they have hearing or vision impairments.

We're here to hear from you about how well your needs are being met, where you are getting these needs met, and some suggestions about how to meet your needs better.

Before we get started, we'd like to establish some ground rules:

- Confidentiality -- don't repeat what you hear here; your comments will not be attributed to you
- Respect each other; we don't all have to agree -- were interested in hearing from people with different points of view.
- We are looking for practical ways of improving services -- things that can be done without a lot of new money.

Discussion

Substance abuse

1. Have you or someone you know needed services for addiction or substance use (substance abuse counseling/ treatment, 12 step groups, detoxification, residential treatment)?
2. If so, were you able to get those services here?
3. Did the services meet your (or your friend/family) needs?
4. Do you have any ideas on how to make those services better?

Mental health

5. Have you or someone you know needed services for mental health (psychiatrist, therapy, emotional support)?
6. If so, were you able to get those services here?
7. Did the services meet your (or your friend/family) needs?
8. Do you have any ideas on how to make those services better?

People who don't speak English

9. Do you know people who cannot get HIV care because they don't speak English?

People who may not see or hear well

10. Do you know people who cannot get HIV care because they are blind or deaf or have some other disability that makes Council into services difficult?

HIV Health Services Planning Council

City Hall, Room 201, Mayor's Conference Room
1 Dr. Carlton B. Goodlett Place

June 23, 2003
4: 30 PM - 7:30 PM

DRAFT MINUTES

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I. Call to Order

The meeting was called to order at 4:30pm.

II. Roll Call

See attachment A.

III. Review and Approval of Agenda

Item XIV and the budget portion of item VIII were postponed until the July 14th Council meeting, item XIII was allowed a longer time because of additional materials. The amended agenda was then approved by consensus.

IV. Review and Approval of Minutes May 27, 2003

Steve Solnit was the person who presented in item VII. After the minutes were amended, the minutes for May 27, 2003 were approved by consensus.

V. General Announcements

Donald Frazier announced he would be leaving early and this Saturday is the Bayview Opera House Health Expo from 9:00- 2:00pm. This would be an appropriate place for the Council to do outreach for the Community Forum, and he requested a table to pass out materials as well as flyers for the Community Forum. In the radius of Southeast Community College, there are 72 churches so it will be important to get clergy involved.

Brad Hume announced he went to Continuum, an adult day health program that is a form of an ISP though not under the ISP category, and had a congregant meal. This was a very eye-opening experience and he would encourage Council members to go out into the community.

Randy Allgaier announced that Medicare is going through both the House and the Congress and an analysis looking at ADAP and Medicare programs will probably be out in the next two weeks.

Catherine Geanuracos announced there will be a joint meeting with the Prevention Council on August 5th at the Walden House (15th and Mission), 2nd Floor, the Cesar Chavez Hall from 5:00-7:30pm.

Donald Frazier announced that the issue around the People of Color demographic and perhaps this could go to discussion at the planning committee.

Hywel Sims (Shanti) announced the recruitment for the new Director of Community Support has been completed and Joe Fera will join us on July 1, 2003. Brad Hume thanked Shanti.

Brian, a consumer, announced that he had sought services through homeless and substance abuse services where he spent time at Walden House and Ferguson Place. At these places, people living with HIV are not allowed to hold their own medications. Also clients are sometimes told medication will only be given to them at two set times, this can be a problem. In addition, when he was in a CAE bed at a men's shelter he was told he was "sick" and this is no an appropriate thing to tell someone living with HIV.

Bill Hirsch announced that a grant was received from HUDD and there will be a forum to highlight housing issues for people with disabilities. If interested please call 701-1200 ext. 308. The next meeting will be July 16th at 1:00pm.

Steve Gibson (Prevention Council) announced an invitation to Magnet Open House, July 1st from 3:00-8:00pm at 4122 18th Street. Magnet will be providing health services in the Castro for gay men.

Thomas Simpson announced Slammin' AIDS, a collaboration from AIDS education of youth in Arts. If you would like to participate, please let him know.

Jim Illig (Project Open Hand and HIV Provider Network) announced that this is the last chance to speak to the city budget committee for the public. The supervisors have prioritized seniors, mental Health and youth; some things are still on the table so come Wednesday at 6:00pm to speak.

VI. Public Comment

Patrick Monette-Shaw submitted his written comment:

The B.A.R. reported June 14 SF AIDS Czar Mike Shriver has been on disability leave for a year-and-a-half; he's actually been missing-in-action for 21 months which, rounding up, is two years. Shriver reportedly believes his disability "has to be respected," claiming he doesn't "owe anything [to anyone]."

SF has approximately 15,000 PLWH/A (depending on which flawed databases, including REGGIE, one chooses believing) relying on our AIDS Czar to advocate for their needs. Should 14,999 PLWHA subsume their needs to protect one nowhere-to-be-found Czarina? Shriver co-issued a pathetic 14-page abridged HIV Consensus Report in 2001, after failing to complete a 150-page unabridged report; SF's last unabridged consensus report was dated 1997.

This Council should advocate strongly with the Mayor's Office for, at least, a temporary Czar replacement, as 14,999 PLWH/A deserve an able-to-serve, and on-duty, AIDS Czar to advocate for their needs properly. The Mayor owes us an AIDS Czar.

VII. Presentation- Homebound Needs Assessment

Michael deMayo and Mitchell Cohen from LaFrance Associates presented the Homebound Needs Assessment. This was a follow up assessment from the 2002 Needs Assessment. At the end of the month, they should have the exact numbers from the homebound population. For more information on the presentation, please refer to the handouts or the audio recording.

VIII. DPH AIDS Office Budget Update and RFP process

Jimmy Loyce or another representative from DPH will come on the July 14th meeting to give a budget update. Michelle Long Dixon explained there is a planned 2-year process in which everything is going out for bid. This is because of requirements from the federal and local government that categories must be competitively rebid. In rebidding providers will be able to adjust for the cost of living. A list of the current fiscal year contract going out to bid was passed out; these would begin in March 2004. Many are single contracts but the bottom half are of primary interest and include service categories. The DPH would like to make sure they are including the Council's ideas and priorities, and certainly, the Council's funding levels as these are put out to bid. The timeline these go out to bid has changed in order to incorporate the Council's decisions. It is easier to change this through the bidding process than to de-fund programs. As part of the solicitation process DPH does community input meeting and that information was sent around.

Brad Hume mentioned it was good to hear the RFT will not be sent out until September and in the future it would be a good idea to coordinate the efforts of the Council and the AIDS office more closely together. Brad Hume also asked if the Council would be able to see the results of the community input meetings. Russ Zellers said the Council would receive this information. Bill Blum asked what categories are going out to bid for 2005. Russ Zellers stated that pretty much everyone, which is not going out now. Mary Lawrence Hicks asked how the time line would go for September. Russ Zellers said some will be sent out first and others later in the process but they will be negotiated for March of 2004 and DPH is trying to give at least six weeks to develop a response. Lara Salle asked if the DPH projects would also have to rebid. Russ Zellers stated they are looking into a different process for this.

Susan Shea announced this is a big opportunity to look at these categories and it would be better to look ahead than to de-fund agencies later. The Council needs to have better monitoring of substance use services. She also asked which of the categories the Council has influence on. Russ Zellers responded that everything which says title one is what the Council controls. Brad Hume, understanding that HRSA has a policy about re-bidding, how often will these go out to re-bid in the future. Russ Zellers stated every four years unless it is indicated as a renewable. They are still checking on HRSA but in the past, they have been hesitant to do this because it is disruptive for the systems of care. Bill Blum asked if the delay in prioritization result in different dollar amount. In addition, DPH should make sure the City bids are competitive with the community organizations. They should be able to bid against each other.

Patrick Monette-Shaw provided the following written comment:

Council member Susan Shea just stated that it is difficult to de-fund CARE agency recipients, and suggested defunding now current CARE Act funded agencies in SF that are not prioritized and designated as Integrated Service Providers, rather than waiting for two to three years to defund them then. This Council has been attempting to channel a greater proportion of SF's CARE funds to ISP programs for the past four years, despite significant inherent known problems with these programs that the Council is aware of. At Health Commission meetings,

DPH has asserted it has the ability to cancel contracts with 30-day notices. De-funding non-ISP programs now is both premature and totally unnecessary, and I urge this Council not to do so just to channel CARE funds to the very ISP agencies who already have significant problems providing services to PLWH/A. This Council should ignore Ms. Shea's premature, specious, and unwarranted rationale.

IX. ADAP/ Medi-Cal Update

Jeff Byers gave a brief ADAP/Med-Cal update. There was no support for co-pays so it looks like this will not be an issue this year though it will still go to the governor's office. The therapeutic monitoring program is being reduced, from 9 million to 1 million for the state, to help shore the ADAP program. This will help inform the process of what to do with Ryan White monies. There might be an ability to establish waitlists; at the end of the year, they might eliminate some drugs. Jeff Beyers does not have the recommendation of what drugs might be cut.

X. Dinner Break

XI. Medi-Cal representative vote

Medi-Cal has nominated a new representative for the Council, Valerie Flood. The Council voted on Valerie Flood's membership. No one opposed the new Medi-Cal-representative to be Valerie Flood. The membership committee will follow up with Valerie Flood and Medi-Cal and invite her to speak for a few minutes at an upcoming Council meeting.

XII. Minority AIDS Initiative Presentation-

Laura Thomas (AIDS Office) gave a presentation of the Minority AIDS Initiative Funds for the San Francisco Eligible Metropolitan Area, fiscal year 2003-2004. The report included summaries from last years funding process, information from HRSA, and what is in the Council's three-year plan. The amount of money designated by HRSA as Minority Initiative Funds is created using a formula based on population. San Francisco EMA receives a relatively small amount because there are fewer cases among people of color. For more information on the presentation, please refer to the handout or audio recording.

XIII. Review Report on ISP

Susan Shea presented a review of Integrated Service Providers. For more information on this presentation, please refer to the handout or audio recording.

XIV. Review Results of Prioritization 2002/2003

Brad Hume gave a brief review of last year's prioritization process. The shared values and visions of the Council are something that should be referred to and remembered. The AIDS office provided Service Category Summary Sheets, which will be provided again this year. The needs assessment, availability, and capacity were looked at. There was a Community Forum and consumers were asked to rank services in the order of importance, Council members did the same. The client costs per unit of service were examined. The Council prioritized the sub-categories, starting with the first, then the bottom tier and lastly the middle tier, which took the most time. From this the list for last year was developed. Some items were moved around in order for the AIDS office to report then as HRSA categories. The final phase was to decide on funding, if it was increase, flat or decrease. Some were held harmless meaning they would not be taken out. An Increase was supposed to go to the top tier, if flat funding the Council was going to take 5% from the bottom tier and move it up and a decrease

would be taken from the bottom tiers. The Council did get an increase and it was put into the top categories.

Discussion followed:

Susan Shea explained that before this point, the council decided the year before to cut every program across the board and it was decided they would never do that again. Many felt that was not prioritization. Then every contract had to be re-done, taking a lot of time. Council members should start thinking about this issue.

Catherine Geanuracos reminded the Council of the decision to make prioritization decisions along the way and not to wait until the last meeting in August. Recommend starting this by the next meeting to again narrow the decisions to focus more closely on some specific issues. She will try to bring a vote on this to the next council meeting, if anyone needs further discussion of this please come to the planning committee meeting tomorrow. George Simmons explained a lot of time was put into this so it would be helpful if everyone looked it over.

Charlene Pugh asked when the Council would receive the Sub-Category sheets. It was explained they would start with the first half at the next Council meeting.

Dirk Doepfner mentioned it is still valuable to look over the needs assessment when looking over the list.

Margot Antonetty voiced concern that the extra Council meeting is when this vote will take place.

Public Comment:

Naomi Prochovnick (Continuum) commented that this year San Francisco received an increase but the AIDS office had sent out de-funding letters and only because money was put back did this not happen.

XV. New Service Category Listing

This item was tabled until the July 14th Council meeting.

XVI. New Business

There was no new business mentioned.

XVII. Next Agenda

Laura Thomas asked if the Council wanted to add a pre-meeting training on July 14th, the next one is scheduled for the July 28th meeting. Susan Shea stated the Title IV collaboration had just done a needs assessment by and about women. They have a great presentation and she will try to plan them for the July 14th meeting.

Joseph Cecere announced that at the planning committee meeting there would be some discussion of the cognitive report.

XVIII. ADJOURN

HIV Health Services Planning Council

City Hall, Room 34
1 Dr. Carlton B. Goodlett Place

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July 14, 2003
4:30 PM - 7:30 PM

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DRAFT AGENDA

I. Call to Order 4:30 PM

II. Roll Call 4:32 PM

III. Review and Approval of Agenda 4:35 PM

IV. Review and Approval of Minutes June 23, 2003 4:40 PM

V. General Announcements 4:45 PM

VI. Public Comment 4:50 PM

VII. Budget Update: SFDPH/ AIDS Office 5:00 PM

Brenda Walker- DPH

Current DPH-wide and AIDS office city budget outlook.

Public Comment on this item

VIII. New Service Category Listing 5:20 PM

Susan Shea

Review of changes adopted by the planning council in service category titles and implications for this year's prioritization.

Public Comment on this item

IX. Service Subcategory Summary Sheets (1st half) 5:40 PM

Laura Thomas

Presentation of summary documents prepared by the AIDS office staff, including utilization, units of service, unduplicated client count, etc. per service subcategory.

Public Comment on this item

- | | |
|--|-----------------|
| X. Dinner Break | 6:00 PM |
| XI. Defining Centers of Excellence
<i>Vote on the definition of Centers of Excellence.</i>

<i>Public Comment on this item</i> | 6:15 PM |
| XII. Community Outreach and Advocacy Committee
<i>Committee report</i>

<i>Public Comment on this item</i> | 6:45 PM |
| XIII. Planning Committee
<i>Committee report</i>

<i>Public Comment on this item</i> | 6:53 PM |
| XIV. Membership Committee
<i>Committee report</i>

<i>Public Comment on this item</i> | 7:01 PM |
| XV. Evaluation Committee
<i>Committee report</i>

<i>Public Comment on this item</i> | 7:09 PM |
| XVI. Infrastructure and Policy Committee
<i>Committee report</i>

<i>Public comment on this item</i> | 7:17 PM |
| XVII. New Business | 7: 25 PM |
| XVIII. Next Agenda | 7:29 PM |
| XIX. Adjourned | 7:30 PM |

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*HIV Health Services Planning Council
730 Polk Street San Francisco, CA 94109*

*San Francisco Department of Public Health, AIDS Office
25 Van Ness Avenue, 5th floor, San Francisco, CA 94102*

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San Francisco

HIV Health Services Planning Council

City Hall, Room 34
1 Dr. Carlton B. Goodlett Place

July 14, 2003
4:30 PM - 7:30 PM

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DRAFT MINUTES

I. Call To Order

The meeting was called to order at 4:30 p.m.

II. Roll Call

See attachment A.

III. Review and Approval of Agenda

The agenda was approved by consensus.

IV. Review and Approval of Minutes of June 23, 2003

The minutes were tabled for revision until the next Council meeting on July 28, 2003.

V. General Announcements

Bill Blum announced San Mateo has a position open for a HIV Risk Reduction Specialist and Health Educator.

VI. Public Comment

Patrick Monette-Shaw submitted his written comment:

The parliamentarian who made a presentation to this Council last year was probably inaccurate when he advised you that subcommittees are not held to the same requirements under San Francisco's Sunshine Ordinance, and that you are not required to post meeting agendas 72 hours in advance for subcommittees. Deputy City Attorney Ann Alpers, when she briefed this Council earlier this year indicated just the opposite: that all subcommittees are to post meeting notices and agendas 72 hours in advance. On several occasions recently, I have received e-mail notices when I return home at night enclosing the agenda for various subcommittee meetings that are held on the same day that I had

received the notice. When is this Council going to start abiding by the Sunshine Ordinance for all subcommittees?

Catherine Geanuracos replied Committee meeting agendas are being posted and sent out to the Yahoo! Group and are posted on the Council's website (www.sfcarecouncil.org).

Bill Hirsh (AIDS Legal Referral Panel) announced AIDS Legal Referral Panel is taking over a CARE funded program of legal services for immigrants who are HIV +, for the remainder of this contract year. They will be accepting new applicants in the near future.

Joe Fera (Director of Community Support) announced Richard Bargetto (HIV Consumer Rights Advocate) is taking a leave of absence and will only be in the office on Monday and Wednesday from 8:00 a.m. to 3:30 p.m., for the next six weeks.

VII. Budget Update: SFDPH/ AIDS Office

Brenda Walker from the Department of Public Health presented the Department of Public Health budget for year 2003-2004. The DPH budget presented is not finalized, and will have a second reading on July 22, 2003. For more information, please refer to the handouts or the audio recording. The highlight is a possible \$500,000 add back from the Board of Supervisors to the Ryan White Care Act.

Patrick Monette-Shaw submitted his written comment:

Brenda Walker just presented an overview of the FY 03-04 AIDS Office budget and distributed handouts showing the Board of Supervisors added back \$500,000 to backfill "federal assistance cut due to the federal funding formula," but this is specious reasoning. This EMA received an increase to the formula portion of its FY 03-04 award. The Board is using this year's General Funds to restore cuts made two years ago to this EMA, at the expense of funding other programs. This is not a "relatively small amount of money," as Bill Hirsh just testified; it would have saved other community programs. Some African Americans I know are fed up with that outreach for other diseases is not occurring, for instance sickle cell disease, because AIDS Inc. has such a disproportionate influence on this Board of Supervisors. These kind of duplicitous add backs will eventually result in a backlash of public opinion.

VIII. New Service Category Listing

Susan Shea handed out a revised Service Category listing, which included changing the sub-categories to match HRSA (Health Resources and Services Administration) categories. On the left side of the handout are the Council's sub-categories, which the AIDS office took and placed in the appropriate HRSA category. The Council will have to begin changing over to the HRSA categories in the future. Please refer to the hand out for more information.

IX. Service Subcategory Summary Sheets (1st half)

Laura Thomas (DPH- HIV Health Services) presented the first half of the Service Category Summary sheets. The second half of the Service Category Summary Sheets, which will include the top eleven service categories, will be presented at the next Council

meeting on July 28, 2003. The budget information included in the Summary Sheets is for San Francisco only and does not include the other counties represented in the EMA (Eligible Metropolitan Area). Included in this year's Service Category Summary sheets is an identification of categories that are going out to bid this year. Catherine Geanuracos asked the Council members to please review the Service Category Summary sheets and come prepared with any questions at the next Council meeting, July 28, 2003. For more information, please refer to the handouts.

Public Comment:

Tim Patriarca (Maitri Hospice) commented on Facility Based Home Care. He indicated that there are five providers in the same category as Maitri and the other providers receive the majority of the funding. Maitri has only fifteen beds but has the greatest amount of residents because they work with the critically ill. Mr. Patriarca suggested that communication between the AIDS Office and providers be improved so that providers have clear information about when their input can be heard.

X. Dinner Break

XI. Defining Centers of Excellence

The Planning Committee Co-Chair Bill Blum presented a definition of Integrated Services (see attachment B) to the Council and moved that the Council adopt the definition. Council members discussed the definition. Susan Shea made a motion to change the wording "centralized location" to "in a collaborative network". The Council then spoke to the second motion. Council Co-Chair Frazier called the second motion to question. Council member Antonetty opposed. Co-Chair Geanuracos asked for a show of hands on whether or not to call the second motion. Of 16 members present, two opposed, therefore the question was called. The second motion was voted on and did not carry. (See attachment A.)

Council member Sanders then called the first motion, whether or not to accept the Definition of Integrated Services as written. Co-chair Geanuracos polled the members whether or not they were in favor of taking this first motion to a final vote. Failing a two-thirds majority, (9 Yeas, 7 Nays) the motion was sent back to the Planning Committee for further work on the language of the Integrated Services definition.

XII. Community Outreach and Advocacy Committee

The Community Outreach and Advocacy Committee has been working on the planning of the Community Forum in the Bayview-Hunters Point area. The forum will be held at Southeast Campus of City College on July 31, 2003 from 5:30 to 8:30 p.m. Donald Frazier has been networking and doing outreach to community leaders in the Bayview-Hunters Point area. He has also been in contact with many of the Pastors in this area and in order to mitigate some of the stigma attached to HIV in the community, they have offered to take HIV tests prior to the event. The DPH testing van will be on-site and testing will begin around 4:30 p.m. The testing van will remain on-site during the forum.

Shanti has agreed to help with transporting clients from programs to the Community Forum.

XIII. Planning Committee

The Planning Committee did not report on Committee activities after presenting the Integrated Services discussion and vote.

XIV. Membership Committee

The Membership Committee is going to have a meeting on Wednesday July 23, 2003 from 4:30-6:30 p.m. to interview new applicants. The Committee is actively recruiting unaffiliated HIV+ Latino/as, and asks that all council members assist them in this recruitment. The Committee will present slates of new candidates at the upcoming July and August Council Meetings. New members must be appointed by the mayor no later than September 1, 2003. All membership applications should be sent to Joe Fera, Director of Community Support.

XV. Evaluation Committee

The Evaluation Committee met and discussed their goals and possible overlap of tasks with other committees. The Committee is going to evaluate the Council's prioritization process this year.

XVI. Infrastructure and Policy Committee

The Infrastructure and Policy Committee is having a meeting on Thursday, July 17, 2003 at 5:30-6:30 p.m., to review a draft of the MOU (Memorandum of Understanding) between the Council and the AIDS Office. This committee only has three home committee members and would like to have a few more members added.

XVII. New Business

There was no new business stated.

XVIII. Next Agenda

XIX. Adjournment

The meeting was adjourned at 7:28 p.m.

- San Francisco

HIV Health Services Planning Council

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July 28, 2003
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DRAFT AGENDA

- I. **Call to Order/Roll Call** 4:30 PM
- II. **Review and Approval of Agenda** 4:32 PM
- III. **Review and Approval of Minutes** 4:35 PM
From June 23, 2003 and July 14, 2003
- IV. **General Announcements** 4:40 PM
- V. **Public Comment** 4:45 PM
- VI. **Conflict of Interest** 4:50 PM
Annual Conflict of Interest Training for Council members. (Norm Nickens)

Public Comment on this item
- VII. **Populations of Interest - VOTE** 5:10 PM
Planning Committee will discuss the Severe Needs Definition, discussing the need for highlighting African-Americans, Transgender and residential substance abuse for Latino/a for Council discussion and vote.

Public Comment on this item
- VIII. **Integrated Service Model Definition- VOTE** 5:35 PM
Planning Committee presents the Integrated Service Model (ISM) Definition for Council discussion and vote.

Public Comment on this item
- IX. **Election of New Members - VOTE** 5:50 PM
Membership Committee will present a slate of new candidates for Council membership

Public Comment on this item

X. Dinner Break 6:00 PM

XI. Service Subcategory Summary Sheets (2nd half) 6:15 PM
Laura Thomas

Presentation of summary documents prepared by the AIDS office staff, including utilization, units of service, unduplicated client count, etc. per service subcategory.

Public Comment on this item

XII. REGGIE Training 6:45 PM

Presented by Laura Thomas and colleagues, continuing REGGIE training for Council members

Public Comment on this item

XIII. A IDS Office Contract Monitoring 7:10 PM

Quarterly Report from Michelle Long Dixon, Director HIV Health Services

Public Comment on this item

XIV. ADAP/Medi-Cal Update 7:20 PM

Monthly update on recent ADAP/Medi-Cal developments presented by Jeff Byers, Council members and representative of State office of AIDS.

Public Comment on this item

XV. New Business/Next Agenda 7:25 PM

XVI. Adjournment 7:30 PM

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*San Francisco Department of Public Health, AIDS Office
25 Van Ness Avenue, 5th floor, San Francisco, CA 94102*

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HIV Health Services Planning Council

City Hall, Mayor's Conference Room (Rm. 201)
1 Dr. Carlton B. Goodlett Place

July 28, 2003
4:30 PM - 7:30 PM

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Draft Minutes

I. Call to Order/Roll Call

The meeting was called to order at 4:30 p.m. See attachment A for Roll Call.

II. Review and Approval of Agenda

The Reggie Presentation, agenda item XIII, was moved up on the agenda, to behind the Conflict of Interest Training, agenda item VII. The amended agenda was approved by consensus.

III. Review and Approval of Minutes June 23, 2003, July 14, 2003

The Minutes of the June 23, 2003 Council Meeting and the July 14, 2003 Council Meeting were approved by consensus.

IV. General Announcements

Council Member Ken Pearce introduced Valerie Flood, the Council's new Medi-Cal representative.

This Council Meeting's pre-training session was the Title IV Women's Consumer Group. A summary of the presentation will be sent out to the Yahoo! Group.

V. Public Comment

Larry Pink spoke for the reinstatement of City Money for the American College of Traditional Chinese Medicine's services. He suggested that the Council should consider using some of the funds from the Board of Supervisors to reinstate these services.

A member of the public also spoke for the American College of Traditional Chinese Medicine, stating that the services provided are invaluable and can help people whom are resistant or cannot tolerate anti-viral medications.

VI. Conflict of Interest

Norm Nickens presented a training about conflict of interest for the Council. Copies of the presentation were passed out. The presentation along with the HRSA guidelines will be sent out to the Yahoo! Group. All Council Members should have some form of conflict; it is best to acknowledge that conflict is there. The Council must file a state mandated annual report to

disclose any conflict of interest of the members and any gifts given to the Council. Members must also sign a written statement to voluntarily disclose potential conflicts. It is the Council's responsibility to decide if a member with a potential conflict of interest can vote on the item being discussed. It is best to disclose these potential conflicts at the beginning of a discussion. If the Council feels the potential conflict is a direct conflict of interest (e.g. a member might gain financial benefit), then the Council member with the conflict will not be allowed to vote on the item being discussed. In the past council members with a conflict of interest have participated in the discussion and did not vote. At the next Council meeting on August 25, 2003, the Council will fill out the Conflict of Interest Disclosure Form. For more information on the presentation, please refer to the handout or the audio recording of the meeting.

XII. REGGIE Training

Steve Solnit and Laura Thomas did a presentation of the Reggie data of the current Integrated Service Providers (ISPs). Copies of the presentation were handed out to the Council. For more information on this presentation, please refer to the handout or the audio recording.

VII. Populations of Interest- VOTE

Council Member William Blum announced that the Planning Committee would like to invite the Council to attend the Committee's upcoming discussions. The Committee did not have a quorum at its last meeting but the members present at the meeting were interested in looking at funding in relationship to the populations of interest, highlighted from the Severe Need Definition. The Committee will also discuss the contract bidding process and the add-backs from the Board of Supervisors; if you are interested in these topics please come to the next Planning Committee meeting on August 12, 2003 from 3:30-5:30 p.m.

VIII. Integrated Service Model Definition (ISM)- VOTE

Council Member Lara Salle presented a new motion for a revised ISM definition based on the discussion at the last Council Meeting on July 14, 2003. The revisions were made in the second paragraph of the definition, and the rest of the definition is the same as the ISM definition presented at the last meeting. Revised second paragraph (with major changes in wording bolded):

*An integrated services model (ISM) of health and social service delivery is one where all ISM services are provided and coordinated by a multidisciplinary team. ISM services are delivered to clients in the vicinity of their primary care and can be provided by a single organization or a **multi-agency collaborative network**. An ISM ensures that populations with severe needs have direct access to a comprehensive spectrum of care that is delivered seamlessly, in a culturally competent manner, and in accordance with the relevant San Francisco EMA Standards of Care for Client-Centered Services.*

George Simmons seconded the motion. There was no discussion. The Council voted on the motion and the motion passed. (See attachment A)

IX. Election of New Members- VOTE

The Membership Committee presented five membership nominees to the Council for a slab vote. The nominees were:

Walter Miller Jr.

Natalie Isaac
Jesus Guillen
Donald Soto
Geraldo Perez

The Council voted and approved the new members by consensus.

The Membership Committee thanked the nominees, Michelle Long Dixon and everyone who helped with membership in the last few weeks. The Committee also asked Council members to attend their committee meetings; at some point, in the near future committees will be assigned to those members who have not chosen a home committee.

X. Dinner Break

XI. Service Subcategory Summary Sheets (2nd half)

Laura Thomas (HHS) handed out part two of the Service Category Summary Sheets. She mentioned that the sheets had changed since she sent them out on the Yahoo! Group and she will repost the revised version. The first part of the Summary Sheets (handed out at last meeting), contains an extensive guide. In the future, the big differences in dollar amounts or units of service from year to year will be footnoted. Emergency Housing is now separate from Direct Financial Assistance, and in the Benefits Counseling section only one program is funded with Title I dollars. Laura Thomas encouraged feedback about the formatting of the summary sheets and other ideas regarding what is or is not useful or suggestions to add information.

XIII. A IDS Office Contract Monitoring

Michelle Long Dixon informed the Council that HIV Health Services (HHS) has made progress certifying contracts. The Standards of Care are also part of Quality Management and two working groups are scheduled to be held in the near future for case management, and supplements and food. All Council members should have a Standards of Care binder, if not please see Council Support. She also announced the amount of the Unfunds (\$770,297) and recommended that the Planning Committee look at making some decisions on how these dollars should be spent so HHS can make a request to HRSA.

XIV. ADAP/Medi-Cal Update

Jeff Byers gave a brief update on the ADAP budget. It continues to appear as if co-pays will not be an issue this year and the completed budget will go forward. There is a large cut in the funding for the Diagnostic Assay program and San Francisco is a heavy user of this program. The Planning Committee might want to consider this cut when looking at funding considerations.

XV. New Business, Next Agenda

No new business was announced.

XVI. Adjourned

The meeting was adjourned at 7:31 p.m.

**HIV Health Services Planning Council
&
HIV Prevention Planning Council Meeting
Tuesday, August 5th, 2003
5:00-7:30 pm**

**Walden House
1885 Mission at 15th Street
Cesar's Hall, 3rd Floor
San Francisco, CA**

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Agenda

Meeting called by Co-Chairs of Both Planning Councils

5:00 pm	Welcome and Introductions	Gwen Smith & Catherine Geanuracos
5:10 pm	General Public Comment	Gwen Smith & Catherine Geanuracos
5:20 pm	Vision for Prevention with Positives- <i>Brainstorm</i>	Gwen Smith & Catherine Geanuracos
5:30 pm	Guidance on Prevention with Positives from Funders and Councils	Steven Tierney & Laura Thomas
5:40 pm	Report on Assessment of Current Prevention with Positives Programs	Michael De Mayo
6:20 pm	Break	All
6:30 pm	Small Group Work on Collaborative Efforts 1. Linkages from testing to care 2. Where in care can prevention have its greatest impact 3. Gaps in prevention programs with positive individuals 4. Issues around substance use and mental health related to prevention with positives 5. Key components of a Partner Counseling and Referral (PCRS) Program	Co-Chairs of Both Councils
6:50 pm	Report Back from Small Groups and Discussion	Gwen Smith & Catherine

Geanuracos

7:15 pm

**Next Steps/Summary of Meeting: Vision for Prevention
for Positives**

**Gwen Smith
and Catherine
Geanuracos**

Note: All meetings are open to the public and are held in handicapped accessible facilities. Allotted time periods for agenda items are approximate and may require adjustments.

UPCOMING HPPC MEETINGS:

Community Liaison: Monday, **August 21**, 2:00 - 3:30 PM, 25 Van Ness Avenue

Plan Policies: Tuesday, **August 26**, 12:30 – 2:30 PM, 25 Van Ness Avenue

Steering: Thursday, **August 28**, 3:00 – 5:00 PM, 25 Van Ness Avenue

Plan Policies: Tuesday, **September 2**, 12:30-2:30 PM, 25 Van Ness Avenue

Plan Research: Thursday, **September 4**, 3:00 – 4:30 PM, 25 Van Ness Avenue

Membership: Monday, **September 8**, 3:00 – 4:30 PM, 25 Van Ness Avenue

Full Council: Thursday, **September 11**, 3:00 – 6:00 PM, City Hall, Room 201, San Francisco

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Note: Agenda items are subject to change, postponement, or removal. Meeting agendas are considered to be in DRAFT form until reviewed and approved by Committee attendees.

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HIV HEALTH SERVICES & HIV PREVENTION PLANNING COUNCILS

Joint Meeting

Minutes

August 5, 2003

Members Present:

Margot Antonetty (HSPC)
Gayle Burns (HPPC)
William Blum (HSPC)
Catherine Geanuracos (HSPC)
Darnell Durio (HSPC)
Lyn Fischer (HPPC)
Steve Gibson (HPPC)
Brad Hume (HSPC)

Janetta Johnson (HPPC)
Thomas Knoble (HPPC)
Joani Marinoff (HPPC)
John Newmeyer (HPPC)
Ken Pearce (HPPC & HSPC)
Charlene Pugh (HSPC)
Andre Robertson (HPPC)
Jorge Rodriguez (HSPC)

Lara Sallee (HSPC)
Mike Schement (HPPC)
Charles Siron (HSPC)
Gwen Smith (HPPC)
Tae-Wol Stanley (HPPC)
Frank Strona (HPPC)
Steven Tierney (HPPC)

AIDS Office Staff:

Francine Austin
Elizabeth Davis
Michael DeMayo
Michelle Dixon

Teri Dowling
Hilda Jones
Betty Chan Lew
Eileen Loughran

John Melichar
Lisa Reyes
Laura Thomas
Russ Zellers

Guests:

Leah Crask - Shanti Project
Colin Eaton - Positive Direction

Val Flood - Nominee to HSPC
Derrick Mapp

Deborah Oliver-Wilson
- ICHO

Harder + Co.:

Dara Coan

David Weinman

Process Evaluation Team:

Emalie Huriaux

Pamela Washington

Welcome and Introduction

Catherine Geanuracos called the meeting to order at 5:07 PM. She welcomed members of the two councils to the meeting and thanked Walden House in whose conference room the meeting was held. She then asked participants to introduce themselves.

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Public comment

There was no Public Comment.

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Vision for Prevention with Positives-Brainstorm

Catherine Geanuracos explained that part of the purpose for this combined meeting of the two councils was to explore the impact of the new CDC Initiative. She said that one of the hopes for the meeting is to find new and different perspectives on Prevention with Positives (PwP). This part of the agenda, she added, is primarily for open discussion and brainstorming.

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- Andre Robinson opened the discussion stating that the councils should ask people who are positive for their perspective(s). He asked if that has been done.
- Ken Pearce discussed a recent meeting held at CMPC Davies, regarding co-infection, positives having sex with positives, and disclosure. He thinks this has a bearing.
 - ⇒ Joani Marinoff asked if co-infection means different strains of HIV.
 - ⇒ He responded that many people with HIV are not aware that there may be other strains of HIV that they may still be susceptible to.
- Frank Strona pointed out that among people living with AIDS (PWA) co-infection has several meanings. He added that it often refers to different diseases: i.e., Syphilis or Hepatitis C.
 - ⇒ He stated that the language used in this matter is very important and currently confusing.
 - ⇒ Many of his clients, he added, are not mindful of prevention, as they are already positive.
- Janetta Johnson stated that some people have the idea when the CD-4 goes up and/or their Viral Load becomes undetectable they are no longer at risk of exposing others.
 - ⇒ She reported that clients report that they get such information from their physicians.
- Andre Robertson stated that many heterosexually identified African-American positive men are very conservative and probably wouldn't avail themselves of services, even if they were there.
 - ⇒ He explained that there are significant differences in attitude toward prevention and services for HIV Positives between young men (20's) and older men (50's): adding that there needs to be some accommodation for these differences.
- John Newmeyer suggested working more closely with communities of faith, particularly to help people get tested.
 - ⇒ He added that the church is often a trusting (and trusted) environment.
- Steve Gibson stated PwP should address co-factors like dealing with depression and other health issues.
- Catherine Geanuracos noted that the two Councils deal with a common community, and that the CDC's concentration on PwP gives the Councils an opportunity to work together in addressing issues of overall wellness.
- Steve Gibson expressed his concern that the community, including HIV positive gay men, are not discussing these issues.
- Thomas Knoble stated that the Councils need to encourage a different perspective on PwP particularly within the context of total health.
- Janetta Johnson said that there needs to be more positive images of HIV positive people.
 - ⇒ In particular, she added that there needs to be more images reinforcing what an HIV positive person does when he/she is doing the right thing.
- It was suggested that the Councils take some tips from programs such as Alcoholics Anonymous whose practices often successfully alter behavior.
- Brad Hume stated that, ultimately, the only way people change their behavior is by giving a damn about themselves.

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- ⇒ He emphasized the need to recognize the various connections between HIV prevention, wellness, and the whole of PWA's life experience.
- Andre Robinson stated that factors contributing to unsafe sexual behavior among PWA are layered and complex.
 - ⇒ He said that he is certain that most people know what causes seroconversion.
 - ⇒ He also said that everyone does stupid things sexually and that people want to have unprotected sex.
 - ⇒ He added that prevention measures need to address underlying issues.
 - In way of example he cited people who have been victims of domestic violence.
- Catherine Geanuracos stated that the stigma surrounding HIV is changing, more and more HIV is being viewed as a chronic, manageable disease.
 - ⇒ She noted, however, that the issues and co-factors influencing HIV remain complex.
 - ⇒ She pointed out that the public's perception of HIV has changed, that the disease seems much less threatening, and asked if this translates into more self-esteem, and/or less risky behavior.
- Frank Strona stated that people do not want to have unprotected sex - people just want to have sex
 - ⇒ He added that the prevention and care communities' task is to make safe sex more natural.

Guidance on Prevention with Positives from Funders and Councils

Catherine Geanuracos introduced Steven Tierney and Laura Thomas whose presentation should provide the funders' perspectives regarding PwP. She also explained that after these presentations members would discuss the impact of the funders' perspective.

Steven Tierney said that he just got back from ten days Atlanta, primarily visiting the CDC. He explained that federal perspective is focusing on PwP. He explained that this concept could be confused with a re-emphasis on the needs of Positives - such as additional funding for ADAP, limiting charges of drug companies, making sure that there is housing and the like. He emphasized, however, that this is not the intention of the new CDC Initiative. The following are highlights of his presentation.

- The federal government's new perspective might better be referred to as "*Preventing Positives*."
 - ⇒ This is an old fashioned public health model based on identifying people who have the virus, identifying their sex and drug partners, and stopping them from transmitting HIV.
 - ⇒ There is nothing wrong with this model if it is part of a comprehensive plan including all of the health services mentioned - adequate housing and medical treatment, etc.
 - ⇒ The federal government's attention is not on health services (the Care Side), but rather on prevention.
- The CDC's projection is that the rate of new cases has been 40,000 per year for the last seven years.

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- The federal government's new emphasis when talking about PwP emanates comes from very conservative side of Congress.
 - ⇒ The Congressional conservatives assert that prevention hasn't worked because it has been directed at people who are negative.
 - ⇒ They want to concentrate on Positives and ensure they don't pass it along.
- Other contentions of the conservation Congress include the following.
 - ⇒ One third of Positives don't know it.
 - The CDC is estimating this to be 180-280,000 people.
 - ⇒ Positives unaware of their serostatus is the primary focus.
 - The thrust, therefore, is to get these people tested, with or without counseling.
- With this influence, the CDC's campaign has four component parts:
 - 1) Counseling and Testing,
 - 2) Partner Services,
 - 3) Perinatal services, and
 - 4) PwP - meaning case management for the Positive person and partner(s).
- During the conference, there was, however no discussion regarding where additional services would come from.
- Representatives from the Department of Human Services asserted that one third of people who know that they are HIV Positive are not getting services.
- The CDC has also been directed to target people who know they are HIV Positive, but not getting services.
 - ⇒ This has been labeled as "*Case Management for Positives*."
- The CDC is concentrating, almost exclusively, on those two groups
 - ⇒ Without increase in funding, this strategy must inevitably mean shifting resources.
- Both of the targeted groups tend to be from communities of color including: undocumented workers, minors, people with criminal justice issues, and people living below the poverty level.
- Steven Tierney also commented:
 - ⇒ If this were part of a comprehensive program, it would be great.
 - However, funds will be shifted from existing programs.
 - ⇒ There is difficulty identifying those two groups without making provision for increasing access to health services.
- In SF the Prevention and Health Services (Care) communities have operated on a loose definition, must now clarify what PwP means.
 - ⇒ The State of CA regulates that 25% of Prevention money goes to PwP, or about \$500K of the \$2M budget.
 - ⇒ The State, however, does not have as clear a view of what that means.
 - It is challenging to allocate 25% to PwP, particularly in hidden populations such as Heterosexually identified MSM - who obviously can't be approached directly - or undocumented workers - who are reticent of getting government services.
 - Without doing extensive case management work it will be impossible to reach these populations.
- The federal government has retreated somewhat and now acknowledges some confidence in:

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- Health education and harm reduction,
- Closing health services disparity, and
- The value of working with the Councils to change their initial focus.
- There are real opportunities to get funding from other sources including the Northern California Grant Makers and the California Endowment who specifically target money to PwP and communities of color.
- Steven Tierney also noted that there is misperception among many funders that SF has sufficient resources, and so SF is often ignored.
 - ⇒ The Councils need to use their resources strategically to improve access to Care, improve healthcare disparity, and to identify those PWA in need of services are.
- He concluded by stating his agreement that they way to find Positives in need of services is to get into the community and ask what is needed.

Steven Tierney then asked for questions and comments.

- Ken Pearce asked if DPH has actual numbers regarding people who are HIV Positive, but unaware of their status and those who are aware of they are Positive, but not in care.
 - ⇒ Steven Tierney stated that the Surveillance Department has statistics, that from memory they include:
 - That Positives unaware of their status to be less than 25%,
 - Between 10-20% know they are Positive but are not in care, and
 - SFDPH believes the total number of Positives is approximately 18,000.
 - ⇒ Steven Tierney added the Consensus Meeting estimated that less than 25% of Positives are unaware of their status - as opposed to the CDC's national estimate of 33%.
 - He explained that up until this year, cases were not reportable so estimates have to be used.
- Brad Hume asked if there is study on the number Positives people receiving services.
 - ⇒ Steven Tierney said that the best information would probably come from a study regarding HAART use, but he did not have the statistic with him.
 - ⇒ He nonetheless noted that this study:
 - Demonstrated that the use of HAART absolutely extends the life expectancy of HIV Positive people, and that
 - Shows that the use of HAART is tied to income and the neighborhoods in SF.
 - ⇒ Steven Tierney also stated that more detailed data from the Surveillance Department can be obtained and forwarded to members of either Council upon request.
- Brad Hume also asked about studies inventorying the medical services people are received, adding that he believes mental health services are being neglected.
 - ⇒ Steven Tierney stated that there are studies that show that people receiving services experience an increase in self-esteem and therefore efficacy of treatments, as well as sustained behavior changes.
 - ⇒ He added that there are equal and other studies that suggest that as people live longer and feel better they tend to revert to previous behavior.
 - ⇒ He also pointed out that this pattern of reverting to old behavior patterns is not unique to AIDS, but shows up in all long-term diseases.

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- People in long-term remission from lung cancer, for instance, often re-start smoking.
- Andre Robertson asked if there are studies that provide information broken down by race.
 - ⇒ Steven Tierney said that the information is not because the numbers are estimates, but that it is probably fair to assume that it breaks down proportionally by race.
- Andre Robertson stated that African-American people are dealing with more immediate issues than HIV - often issues that are just as potentially fatal.
 - ⇒ He also stated that many people in the African-American community probably aren't surprised when they are told they are Positive; that those that don't know don't want to know until they perceive an immediate threat
 - ⇒ He added that he is not surprised that White neighborhoods therefore have a higher percentage of use of HAART.
 - ⇒ Steven Tierney directed members' attention to an article in the New York Times (08/03/03) regarding young African-American men and the struggle regarding "coming out" as well as dealing with HIV prevention.
- Members were informed that a copy of the article, "On the down low" is available upon request.

Laura Thomas from the DPH took the floor and explained that her presentation relates to the particular obligations of the Health Services Council (Care Council) in relation to the CDC Initiative.

- The first obligation is to ensure that Care services are linked with Prevention services.
 - ⇒ One of the reasons for the joint meeting of the Councils is to ensure the Care Council is aware of what the Prevention Council is doing.
 - ⇒ The Care Council's responsibility in the continuum of service is to ensure that people who test positive are connected with available services.
- Both Councils should be aware of one of the requirements for Title One funds relates to the 180-280,000 people that the CDC's initiative intends to identify as unaware of their HIV Positive status.
 - ⇒ Title One funding requires the Care Council to have a plan for how to handle these people
 - ⇒ There doesn't seem to be any intention to increase funding, even with the increased expectation of providing services.
 - ⇒ The specific language from the application reads, "*It is incumbent upon all Title One grantees to fully reassess their priorities and allocations for FY 2004 in the light of this new HIV prevention initiative.*"
 - ⇒ Title One is focusing on the new testing provisions of the CDC Initiative rather than PwP.
- Title One is also concerned the population of people who have tested Positive, but are not currently receiving services.
- The expectations of the Care Council include:
 - ⇒ Identify who these people are, what their needs are, and why they aren't getting services, and
 - ⇒ To devise a framework for handling people who fall into this category.
- The CDC's Initiative would potentially put 35-45% more people into SF Care programs.
 - ⇒ Laura Thomas added that she found it sobering to think how thin that would stretch resources in SF.

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- These requirements are right up front on the Tile One documentation and in bold.

Laura Thomas then asked for comments and questions.

- Janetta Johnson noted that a lot of people test Positive, but are not ready to go to services.
 - ⇒ She pointed out that for some HIV Positive services are not anonymous.
 - ⇒ She added that most of these people could and would work with a confidential Case Manager.
- Janetta Johnson then asked how many of people in prison or jail test Positive for the first time, noting that many act as if nothing has happened when they are released.
 - ⇒ Andre Robinson noted that at San Quentin all prisoners are tested at intake.
 - He stated that HIV status is put in the inmates medical file which creates a permanent record.
 - He also said that many inmates, to avoid the stigma attached, get tested but do not get the results and therefore go untreated.

Report on Assessment of Current Prevention with Positives Programs

Michael DeMayo of DPH was introduced. He explained that the Prevention section asked his department to conduct of survey of what the various Prevention agencies are doing. He distributed copies of his slide presentation entitled, "*Prevention with Positives / Agency Assessment Summary*" a copy of which is available to absent members upon request. In addition to the presentation, Michael DeMayo provided information including the following.

- The study is not an evaluation of PwP programs, rather just an inventory of what is offered.
- The study was limited to Prevention providers, although many Care providers also provide Prevention services to Positives.
- Michael DeMayo drew members' attention to the list of program content categories (pages 8 - 9).
 - ⇒ This list of eleven content types was drawn up by the DPH but is not codified anywhere.
 - ⇒ No agency has specifically defined what PwP, and that it differs from agency to agency.
 - Nonetheless, although not necessarily targeted to Positives, all of the agencies provide some sort of PwP.
 - ⇒ Most agencies did not get input from the Positive community, although many got input from Positive clients and staff members.
 - ⇒ Prevention and Care should be able to form strong linkages in this area.
- There are a few common issues relating to the impact of treatment on prevention noted by providers (page 9) including the following.
 - ⇒ An undetectable Viral Load and a high CD-4 count have given many people the false impression that they weren't as infectious.
 - ⇒ Some of the drugs used in treatment cause erectile dysfunction in response to which some do not use condoms and/or change their sexual behavior to more risky practices.
 - ⇒ The cultural context to prevention in general, including the way it is articulated to different populations.

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- ⇒ For the most part, PwP programs are developing along the same lines, and using the same interventions, as Prevention for people who do not know their serostatus.
- He noted that on the Care side the issues most commonly reported in the survey dealt with disclosure, stigma, and access to healthcare.

Michael DeMayo then asked for questions and comments.

- John Newmeyer asked if there is any research that actually supports the idea that there is a reduction of risk for people with high CD4 and low Viral Load.
 - ⇒ There were several comments on this, mostly dismissive of the concept of higher CD-4 count equating with less risk of transmission.
 - ⇒ It was pointed out, however, that there is some non-definitive indication that a lower Viral Load may actually indicate a reduction in risk.
- Catherine Geanuracos noted with interest that the Agency Assessment Summary does not look at Prevention from the clinician's perspective.
 - ⇒ She pointed out that on the Care side most - although not all - of the services are provided by a Primary Care Provider (PCP) rather than through social support services.
 - ⇒ To reach the greatest number of people, she added, a similar study on the Care side would have to gather information from PCPs.
 - ⇒ Using Larkin Street Youth Services as an example, she stated that the support services/case management side generally handled prevention.
 - PwP as handled by Case Managers would involve disclosure to clients' partners and encouraging clients' partners to seek services.
 - PwP services through PCPs may conflict with medical standards; i.e., regarding disclosure, and the like.
 - ⇒ She added that generally matters of sexuality are better handled in a Case Management context than a medical one.
- Michael DeMayo indicated that another issue raised by many of the providers is the need to train prevention staff regarding healthcare issues.

Small Group Work on Collaborative Efforts

& Report Back from Small Groups and Discussion

Catherine Geanuracos invited attendees to split into the Small Groups to discuss the five issues highlighted below. Dara Coan, Catherine Geanuracos, Gwen Smith, Laura Thomas, and Steven Tierney facilitated the Small Group discussions. The summaries of these discussions were presented, as follows.

1. Linkages from Testing to Care.
 - ⇒ Homelessness issues, SA, MH, poverty, stigma, and more
 - ⇒ Testing must have counseling with it-- the CM + counseling --- the linkages
 - ⇒ So many care related services available, they need CM and counseling
 - ⇒ Linkages/appts need to be made with med/health care providers - not necessary public health

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- ⇒ Need intro to system of care
 - ⇒ Collaboration needed at systems level - prevention and care at DPH need a clear sense of direction
 - ⇒ What is in place now for linkages? What happens when a person gets a positive test result? What is the standard (are there standards? It varies by agency.)
 - ⇒ Barriers
 - Psychological reaction to positive status (returning for results and linking to care)
 - Difficulty with follow-up --- rapid testing could help
 - Status regarding health care access
 - Transportation
2. Where in care can prevention have its greatest impact?
- ⇒ Prevention case managers
 - ⇒ Maintain some separation to catch people who won't go into care due to stigma or public disclosure by going to HIV Care sites
 - ⇒ Primary care settings
 - ⇒ Psychosocial case managers services - "one stop shopping"
 - ⇒ Top 12 doctors
 - Within context of sexual health
 - Cultural competent providers/Care sites
 - Issues of trust building across different communities
 - ⇒ Support groups support behavior change and maintenance
 - ⇒ Doctors
 - 1 time interventions (stage setters) within context of managed care models
 - ⇒ Nurses
 - Large role
 - ⇒ Health educators/peer advocates - most time on-going relationships
3. Gaps in prevention programs with positive individuals?
- ⇒ Substance use
 - ⇒ Substance abuse
 - ⇒ Redefining prevention
 - ⇒ Drugs and sex
 - ⇒ Prevention providers ability to talk about sex
 - ⇒ Systems to monitor & track referrals
 - ⇒ Clarity and consistency with HIV related issues such as:
 - Viral load
 - Co-infections/super infection
 - Risk related to having sex with someone HIV+
 - Acknowledge the limitations of science
 - How much risk are you willing to live with
 - Anxiety related to lack of knowledge

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- ⇒ End of life issues - AIDS is a terminal disease
- 4. Issues in substance use and mental health related to prevention with positives
 - ⇒ Learning style changes
 - ⇒ Not set up to address 3 AAA
 - ⇒ Domestic violence - effecting self esteem
 - ⇒ Sexual abuse as children - effecting self esteem
 - ⇒ Not enough access to Alcohol/Drug treatment and mental health
 - ⇒ If they are HIV- how do we move CHS to become not treatment ready!
 - ⇒ Substance use and sex
 - ⇒ Methamphetamines
 - ⇒ Mental health and SA worker not prevention trained working with partner with program
 - ⇒ Recognizing provider limits
- 5. Key components of a partner counseling and referral program?
 - ⇒ Self-disclosure and/or dis/3rd party
 - ⇒ In San Francisco/provider referral
 - ⇒ Voluntary
 - ⇒ Confidential
 - ⇒ How does detuned test impact?
 - ⇒ Client-centered
 - ⇒ Not linked to testing/integrate with care
 - ⇒ How to incorporate anonymous partners?
 - ⇒ Domestic violence, immigration status, & incarceration
 - ⇒ Community driven (involving and people/community members/CBOs)
 - ⇒ Include :ADAP workers, case managers, peer advocates, outreach workers. What training is needed?
 - ⇒ Funding? Care or prevention? Through which service system?
 - ⇒ Referrals and Care
 - ⇒ Part of standards of care
 - ⇒ Deal with HRSA requirements?

Copies of these summaries were forwarded to members separately. Some discussion among the whole group followed.

- Catherine Geanuracos pointed out that recommendations from the Small Groups would go back to the respective Councils.
 - ⇒ She pointed out that one of the reasons for having the joint meeting now is that the Care Council does its priority setting in August for the following year.
- Brad Hume added that there needs to be a consistent definition of what PwP means, as well as other commonly used terms.

Next Steps/Summary of Meeting: Vision for Prevention for Positives

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Catherine Geanuracos summary of the meeting included these points:

- ⇒ Prevention Case Management as part of how we define the system of care.
- ⇒ Training Case Managers, and other providers, including PCPs in prevention strategies in PwP services.
- ⇒ Ensuring that referrals to and from Substance Abuse services keep in mind the needs of PwP including improving access and integration of Substance Abuse services and Prevention.
- ⇒ Making sure that referrals from Testing into Care and between different services are tracked and documented.
- Catherine Geanuracos also noted that the Care Council is working on an integrated services model that includes many of the elements discussed by the Small Groups, including: Mental Health, Substance Abuse Services, Primary Care, Case Management, and Care Advocacy.
 - ⇒ She stated that the Council would look at how to integrate Prevention services into the model.
 - ⇒ She added that hopefully in addition to Prevention linking into Care services the model will accommodate and track people that do not wish to take the next step.
- Frank Strona suggested a joint committee of the Councils to address the definition of PwP, other terms, and to coordinate how the Councils are going to proceed.
 - ⇒ Gwen Smith added her agreement stating that she was going to propose the same measure.
 - ⇒ Andre Robinson stated this is the next step.
- Catherine Geanuracos stated that the Care Council most certainly would include some provision for more linkages into Prevention services in the 2004-05 budget.
- Catherine Geanuracos pointed out that the suggested next step of establishing a joint committee could not be voted on because there wasn't sufficient prior public notice. However, a working group could be established.
 - ⇒ Brad Hume and Frank Strona volunteered to organize such a working group.
 - ⇒ Catherine Geanuracos suggested getting two or three members for each Council and asked Brad Hume and Frank Strona to solicit participation from absent members.
 - ⇒ These members in attendance volunteered to participate: William Blum, Thomas Knoble, Joani Marinoff, Andre Robinson, and Charles Siron.
- Catherine Geanuracos stated that the joint meeting had been helpful to her and stated her support of having other such meetings at least twice a year.
- Frank Strona noted that members he has talked with, but who are not in attendance, stated that joint meetings should produce an Action Plan which briefly lists the plans and specific tasks the Councils agreed upon.
- Brad Hume stated that he enjoyed engaging with other members rather than just listing to presentations.

Catherine Geanuracos stated that it had been a very productive meeting and thanked attendees as well as Walden House.

The meeting adjourned at 7:27 PM.

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Joint Meeting
Minutes
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Minutes prepared by David Weinman

Minutes reviewed by Eileen Loughran, Leah Crask, and Gwen Smith.

San Francisco

HIV Health Services Planning Council

UCSF Faculty/Alumni House
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August 25, 2003

Lunch at 12:30 PM
Meeting 1:00-8:30 PM

DRAFT AGENDA

I. Call to Order 1:00 PM

II. Roll Call 1:02 PM

III. Review and Approve Agenda 1:05 PM

IV. Review and Approval of Minutes from July 28, 2003 1:10 PM

V. General Announcements 1:15 PM

VI. Prioritization Introduction 1:20 PM

Catherine Geanuracos and Laura Thomas will introduce the goals of the meeting.

VII. Public Comment 1:25 PM

VIII. Conflict of Interest Disclosure 1:50 PM

Council Members disclosure of any possible conflict of interest and turn in the Conflicts of Interest Disclosure Form.

Public Comment

IX. Robert's Rules of Order Review 2:05 PM

X. Presentations of Prioritization Documents 2:10 PM

Brief explanations of each of the following documents:

a. **Decision Matrix**- Antonetty- 2:10 PM

b. **Goals and Objectives from the 3-year plan**- Co chairs-2:20 PM

c. **Budget**- Thomas-2:25 PM

d. **Overview of Studies**-Siron & Allgaier- 2:30 PM

1. Transgender

2. Needs Assessment 2002 and Update

- 3. Party and Play
- 4. Dementia
- 5. Family Services- Title IV
- e. **Community Forum Report-** Durio & Frazier- 2:40 PM
- f. **Summary of the other important documents-**Planning Committee- 2:45 PM
 - 1. Summary Sheets
 - 2. Service Subcategory List-
 - 3. Severe Need Definition
 - 4. Shared Values and Vision
 - 5. Definition of ISM

Public Comment

XI. Discussion of Unfunds-VOTE

2:50 PM

Motion brought forward from the Planning Committee: Motion to allocate \$352,000 for the San Francisco Diagnostic Assay Program, \$150,00 to split between food and household goods vouchers, and \$286,000 to be applied towards Direct Emergency Financial Assistance.

Potential Amendment: Use \$50,000 of funding (reducing DEFA amount to \$236,000) to support focus group/ needs assessment activities in Bayview/Hunter's Point to determine how best to implement/ expand ISM model for that community. Earmark \$50,000 of Supervisor's Addback funding towards DEFA).

Public Comment

XII. BREAK

3:15 PM

XIII. Discussion of the ISM- VOTE

3:30 PM

Motion brought forward from the Planning Committee: The encouragement of ISMs is a multi year project, the first year should focus on contract process by instructing HHS to include contract language and MOUs to include case conferencing for all service categories listed in the ISM definition and to take into account the affect of this on units of service

Motion from the Cochairs: As service categories are put out to bid during 2004 and 2005, providers in all service categories (in a manner determined to be appropriate for each subcategory) should develop and demonstrate linkages to primary care being provided through Integrated Service Models.

Public Comment

XIV. Sub-Category Prioritization- VOTE

4:30 PM

Discuss and vote on subcategories in priority order.

Motion from the Cochairs: Reauthorize subcategory priority order developed during 2003-2004 prioritization, with the addition of Outreach (MAI-funded) as the last item.

Public Comment

XV. Service Category Allocations 2004-2005- VOTE

5:00 PM

Discuss and vote on funding allocations per subcategory.

Motion from the Co-chairs:

The council requests that 30% of the current funding allocation within Outpatient Substance Abuse and Outpatient Mental Health Services be linked to programs meeting the definition of an Integrated Service Model. The council requests that these funds be directed towards services for African American and/or transgender clients.

Public Comment

XVI. DINNER **6:00 PM**

XVII. Membership-VOTE **6:30 PM**

Vote on Council Members term renewals and New Council Members, Cecilia Chung and Rev. Joe McMurray.

Public Comment

XVIII. Funding Scenarios –VOTE **6:45 PM**

Motion brought forward from the Planning Committee: Motion for the Council to adopt last year's funding methodology. (See document *funding scenarios approved by the Council during 2002 Prioritization*)

Amendment Proposed by Cochairs: Direct any potential increased MAI funding to Residential Treatment Programs for Monolingual Spanish-Speaking Clients.

Public Comment

XIX. Open Nomination for CO-Chairs **7:45 PM**

XX. Evaluation Committee **8:05 PM**

Brief explanation of the coming evaluation of the prioritization process.

XXI. New Business **8:15 PM**

XXII. Adjourn **8:30 PM**

Note: Agenda items are subject to change, postponement, or removal. Meeting agendas are considered to be in DRAFT form until reviewed and approved by Council attendees.

HIV Health Services Planning Council

730 Polk St, 3rd Floor, San Francisco, CA 94109

San Francisco Department of Public Health, AIDS Office

25 Van Ness Avenue, 5th floor, San Francisco, CA 94102

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San Francisco

HIV Health Services Planning Council

UCSF Faculty/Alumni House
745 Parnassus (at 5th Avenue)

August 25, 2003

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I. Call to Order

Council Member Hume called the meeting to order at 1:00 p.m.

II. Roll Call

See attachment A for Roll Call.

III. Review and Approve Agenda

The agenda was approved by consensus.

IV. Review and Approval of Minutes from July 28, 2003

The minutes from the July 28, 2003 Council meeting were approved by consensus.

V. General Announcements

It was announced that there was two hour parking around the facility and if anyone needed to step out and move his or her car, please do so at anytime.

Laura Thomas (HIV Health Services) announced she needed to collect the blue forms she sent to all Council Members in the mail, she also has extra copies with her if a Council Member forgot to bring this form today.

VI. Prioritization Introduction

Council Member Geanuracos and Laura Thomas (HHS) introduced the goals of this meeting. They mentioned time for public comment would be limited and there would be a chance for the public to comment before each vote the Council makes. This meeting is the culmination of the Council's activities for the last several months. The goals of the meeting were to make sure the Council is 1.) Reflecting the needs of people living with HIV, 2.) Providing services for the Council's most severe need populations, and 3.) Promoting cost effective services overall. Laura Thomas explained that the decisions the Council makes today are needed for the Title I grant application. These decisions include: service category priority order, dollar amounts in each service category, directions regarding Minority AIDS Initiative Funding, any other directions the Council gives the AIDS Office about implementing priorities, and the funding scenarios.

VII. Public Comment

The public was asked to make comments relevant to the prioritization process and the Council prioritizes based on service categories, not specific programs.

A member of the public spoke and commended the Council on realizing there is an unmet need for family and children's services. Many women and families find services unwelcoming to children, who are their top priority, and often have to leave because they become frustrated with an environment not conducive to children. The Council should also make sure Integrated Service Providers (ISPs) are something actually needed, with components representing the needs of the populations.

A second member of the public spoke on the demands and needs of severe need populations. He challenged the Council to begin to de-fund categories and minimize the harm for those with most severe need. He appealed to the Council to reprioritize Adult Day Health Care in the priorities. If this category is de-funded the impact on clients would be profound, many clients are triple diagnosed and predominantly African American women in the Tenderloin. He believes if this Adult Day Health is de-funded the cost to the system of care would go up and the quality of life of the clients would go down.

A third member of the public spoke regarding Emergency Financial Assistance. The Planning Committee has made a motion for use of the Unfunds in this category, but this is also a long term funding structural issue for the category. About 1000 units are served through CARE and the rest are served through the community and reserves in the agency. He would be grateful to discuss this issue later this afternoon.

A fourth member of the public spoke to encourage the Council to keep its prioritization from last year. He also spoke for legal services and stated that many people do not identify this as critical until they are evicted. This fall legal services for immigrant populations is going out to bid and he encourages the Council to remember this population.

VIII. Conflict of Interest Disclosure

Council Members disclosed of any possible conflicts of interest.

Brad Hume has no conflict of interest.

Jeff Byers is from the State Office of AIDS in Sacramento and has no conflict of interest.

Susan Shea is a primary care provider at UCSF Women's Specialty Clinic, which uses Title I, II, and IV funds and at Ward 86, which is I, II, III, and IV funded.

Gerardo Perez has no conflict of interest.

Darnell Durio is an employee of UCSF AIDS Health Project, which is Title I funded.

Charles Siron has no conflict of interest.

Randy Allgaier has no conflict of interest.

Charlene Pugh has a perceived conflict of interest in dental work; she works at the UOP Dental School.

Elyse Graham has a perceived conflict of interest in complementary therapies; she is the Executive Director of the Immune Enhancement Project.

Valerie Flood represents Medi-cal.

Kevin Johnson works for Catholic Charities, which receives some CARE funds, but the project he works on does not.

Walter Miller Jr. has no conflict of interest.

Ken Pearce has a perceived conflict of interest; he receives services, is a volunteer and board member at the AIDS Health Project and is a board member at AIDS Emergency Fund.

Margot Antonetty works for the San Francisco Health Department, in the Housing and Urban Health office.

Natalie Isaac does work for national Llego.

Jorge Rodriguez has a perceived conflict of interest; he works for Mission Neighborhood Health Center.

George Simmons is a Program Director at Catholic Charities.

Charles Siron has no conflict of interest.

Donald Soto works for Lutheran Social Services, which receives Title I funds.

Lara Sallee is an employee of SF Community Clinic Consortium which receives Title I funds.

Anita Booker is an employee of San Mateo Medical Center, as the Director of Clinical Trials and Research and is a board member of AIDS Community Research Consortium.

Bill Blum is an employee of San Mateo County AIDS Project, as the Client Services Coordinator.

John Conley is the Deputy Director of Public Health and the AIDS Program Director for San Mateo County Health Services.

Catherine Geanuracos is an employee in the Division of Adolescent Medicine at UCSF; she was formerly employed at Larkin Street Youth Services.

Donald Frazier is the Director of Contracts at Walden House.

Public Comment:

A member of the public stated it would be nice to have a typed list of Council Members conflicts of interest from Council Support.

IX. Robert's Rules of Order Review

Council Member Hume gave a brief overview of Robert's Rules of Order. There are no friendly amendments, only one motion can be discussed at a time, if a committee brings a motion forward it does not need to be seconded, if anyone else brings a motion forward it must be seconded before being discussed. If making a motion to amend the motion on the table, the person who seconded the motion does not need to approve on the amendment, there will be discussion, a vote on the amendment and then go back to the original motion.

X. Presentations of Prioritization Documents

- a. **Decision Matrix-** Council Member Antonetty briefly explained the Decision Matrix document and the Decision Matrix Interpreter.

- b. **Goals and Objectives from the 3-year plan-** The Council Co-chairs briefly explained the goals and objectives from the Three Year Plan. The Council is currently in the first year and is prioritizing for the second year. Part of the plan was to have better linkages with mental health and other Councils.
- c. **Budget-** Laura Thomas explained the budget, which was the same as the one brought to the Council in May, 2003. The first page was arranged by major service category and the second page was arranged in subcategory priority order. In the last column is the projected budget for FY 2004, the changes are that a couple of programs will be moved off of Title I and into the General Fund.
- d. **Overview of Studies-** Council Members Siron and Allgaier gave brief overviews of the following studies: Transgender, Needs Assessment 2002 and Update, Party and Play, Dementia, and Family Services- Title IV.
- e. **Community Forum Report-** Council Members Durio and Frazier announced there is a report for everyone to pick up on the Bayview-Hunter's Point Community Forum. No consumers were at the forum so it is from a provider's point of view.
- f. **Summary of the other important documents-** The Planning Committee mentioned the other important documents, the Summary Sheets, the Service Subcategory List, Severe Need Definition, the Shared Values and Vision, and the Definition of the ISM

Public Comment:

A member of the public commented on congregant meals. This is a critical service in Adult Day Health for diabetic clients, which need to have blood levels drawn in conjunction with food provided to them.

A member of the public commented on the dementia assessment and then that younger adults have some very different needs than other people living with HIV and has the Council reached out to this community.

XI. Discussion of Unfunds-VOTE

Motion brought forward from the Planning Committee: Motion to allocate \$352,000 for the San Francisco Diagnostic Assay Program, \$150,00 to split between food and household goods vouchers, and \$286,000 to be applied towards Direct Emergency Financial Assistance.

The Council discussed the above motion from the Planning Committee, and then decided to take each section of the motion separately. The Council discussed the Diagnostic Assay Program and voted (column 2 on attendance sheet). **The motion to allocate \$352,000 for the San Francisco County Therapeutic Monitoring Program was approved.**

A member of the public submitted his written comment:

This Council and DPH are to be commended for reducing so-called "unfunds" from Ryan White CARE Act monies awarded to our EMA that went unspent in FY '02-'03 to only

\$770,297, an improvement from FY '01-'02's unspent \$1.68 million "unfunds". I know you are working diligently to reduce unfunds to zero, but it is nonetheless shocking that San Francisco's "model of care" is so unwieldy that it leaves money unspent, year in and year out. Particularly troubling is news that \$126,664 (16% of the total) dedicated for housing remained unspent in FY '02-'03. Housing has repeatedly been identified in every needs assessment conducted by this Council as one of the greatest unmet needs. How do you think will homeless people with HIV feel sleeping on the streets each night, knowing the City and this Council couldn't get the money dedicated for housing spent in a timely manner?

The Council then voted on the **motion to allocate \$150,000 for vouchers – split between food and household goods** (column 3 on attendance sheet). The Council approved the motion.

***Potential Amendment:* Use \$50,000 of funding (reducing DEFA amount to \$236,000) to support focus group/ needs assessment activities in Bayview/Hunter's Point to determine how best to implement/ expand ISM model for that community. Earmark \$50,000 of Supervisor's Addback funding towards DEFA.**

Council Member Frazier **changed the potential motion, from 50K to 35K and changed the focus groups/needs assessment to community crafted RFP for an ISM in Bayview-Hunters Point.** Council Member Johnson seconded the motion. The Council will commit to identify funds in 2005-2006 prioritization for one ISM targeting African Americans in the Bayview-Hunter's Point. The Council discussed these changes to this motion. Council Member Frazier withdrew the motion.

There was a new **motion to use 50K of the Unfunds to do community planning in the Bayview Hunter's Point targeting African Americans.** Council Member Shea seconded the motion. The Council discussed the motion and **the motion was changed from 50K to 35K.** The motion was called to question and no one opposed calling the question.

Public Comment:

One member of the public spoke in favor of the motion.

Another member of the public applauded the Council's efforts and challenged the Council to actively recruit a new Council Member from Bayview-Hunter's Point.

The Council then voted on the above motion (column 4 on attendance sheet), and the motion passed.

The third part of the original motion, the balance of the Unfunds (\$233,297) for Direct Emergency Financial Assistance Motion was called to question. The Council voted on this motion (column 5 on attendance sheet), and the motion passed.

XII. BREAK

XIII. Discussion of the ISM- VOTE

Motion brought forward from the Planning Committee: The encouragement of ISMs is a multi year project, the first year should focus on contract process by instructing HHS to include contract language and MOUs to include case conferencing for all service categories listed in the ISM definition and to take into account the affect of this on units of service.

The Planning Committee presented the above motion.

Public Comment:

A member of the public commented with a concern about possible vagueness and there is too much emphasis on a starting point, when Memorandums of Understanding (MOU) are not very effective.

The Council voted on the motion by hand, and the motion carried.

Motion from the Co-chairs: As service categories are put out to bid during 2004 and 2005, providers in all service categories (in a manner determined to be appropriate for each subcategory) should develop and demonstrate linkages to primary care being provided through Integrated Service Models.

Council Member Geanuracos explained the motion from the Co-chairs. Council Member Allgaier seconded the motion. The Council then discussed the motion.

An amendment was presented to say there would be a link to primary care not within an ISM. Council Member Pugh seconded this amendment. The Council then discussed this amendment.

Public Comment:

A member of the public commented in favor of the motion but against the amendment, she would like to make a distinction between the ISM and ISP but the move is more increasingly towards ISMs.

A second member of the public commented that the historically identifying people not in care and helping them access primary care reinforces the ideas of collaborations.

The Council voted on the amendment (column 6 on attendance sheet). The amendment did not carry.

The Council returned to discussion on the **original motion: As service categories are put out to bid during 2004 and 2005, providers in all service categories (in a manner determined to be appropriate for each subcategory) should develop and demonstrate linkages to primary care being provided through Integrated Service Models.**

The Council voted on the motion (column 7 on attendance sheet), and the motion passed.

XIV. Sub-Category Prioritization- VOTE

Motion from the Co-chairs: Reauthorize subcategory priority order developed during 2003-2004 prioritization, with the addition of Outreach (MAI-funded) as the last item.

There was also a motion from the Planning Committee to adopt the order as it stands. Council Member Conley seconded this motion.

Council Member Siron stated **an amendment to the motion to re-categorize Adult Day Health Care as an Integrated Service Provider (ISP).** Council Member Allgaier seconded the motion. The Council discussed this amendment.

Public Comment on this amendment:

A member of the public announced this is the first time the Council would consider something like this, and in 1990 this was a bundle of services not a single service. He cautions the Council to prioritize services and the service mode but to choose the HRSA definitions of services.

A member of the public spoke on behalf of the service category of Adult Day Health Care. He mentioned there is a peer advocate at the Adult Day Health Service and there is a Nurse Practitioner providing primary medical care on-site. This site is a chronic care ISP.

A member of the Public submitted his written comment:

This Council just considered a motion to reauthorize the same subcategories prioritized last August; however, an amendment to the motion was proposed to move the “Adult Day Health Care (ADHC)” category into the Integrated Services subcategory. ADHC provides such things as physical and occupational therapy, among others. I note that this is the third or fourth time during the past year this Council has moved, or attempted to move, subcategories around in the priority list, after having voted last August to approve a “final” priority ranking. Co-Chair Brad Hume just stated ADHC may be defunded entirely next year if San Francisco receives a reduced award for the FY starting next February. If you approve this proposed amendment, you will continue setting a precedent that the Council can keep moving categories around whenever it feels a particularly category faces elimination. I urge the Council to vote “No” on this amendment.

The Council voted on the amendment (column 8 on attendance sheet), and the amendment did not pass.

Council Member Allgaier stated **an amendment to add a subcategory for therapeutic monitoring programs.** Council Member Pugh seconded the amendment. The Council then discussed the amendment. Council Member Allgaier withdrew the amendment.

Council Member Allgaier **reinstated the amendment adding that it would be funded at 0 (zero)**. Council Member Allgaier then officially withdrew the amendment.

Council Member Durio stated **an amendment to move Adult Day Health Care to number 17 on the priority list, below Detox and before Facility Based Home Care**. Council member Siron seconded the amendment. The Council discussed the amendment.

Public Comment:

A member of the public cautioned the Council about mixing priorities up. The Council includes many Members who are not as familiar with services as they are with providers.

A member of the public provided written comment:

Randy Allgaier just introduced an amendment to add a new, ongoing subcategory to the prioritization list titled “Therapeutic Monitoring,” possibly mistakenly assuming it would become an on-going CARE Act-funded need in future years. Several Council members and DPH staff indicated they were extremely uncomfortable discussing adding a new subcategory to the prioritization mix; Allgaier then withdrew his amendment. Did anyone notice the disconnect I noted: During Agenda Item XI, Discussion of Unfunds, this Council approved allocating \$352,000 from Unfunds for “Therapeutic Monitoring” to ameliorate a recent cut by California’s ADAP program, approving using \$352,000 in “Unfunds” for Therapeutic Monitoring, without any discussion whatsoever whether Unfunds would potentially be used for a non-payor-of-last-resort program, a funding decision prohibited by the CARE Act? This Council should have first discussed whether other funding sources were investigated for Therapeutic Monitoring *before* voting, possibly illegally, to use Unfunds to restore this State cut, but didn’t.

The Council voted on the amendment (column 9 on attendance sheet), and the amendment did not pass.

Council Member Graham stated **an amendment to move the subcategory, Complementary Therapy, to number ten (10) on the subcategory prioritization list**. Council Member Johnson seconded the motion. The Council discussed the amendment.

Public Comment:

A member of the public commented that it makes one uncomfortable seeing the Council put an arbitrary number to a category in the priority list, but in favor of the Council moving Complementary Care up on the priority list.

A second member of the public spoke against the amendment and encourage the Council to follow the Three Year Plan, moving towards the ISMs, this category does not serve the Council’s target populations.

The Council voted on the amendment (column 10 on attendance sheet), and the amendment did not carry.

The **original motion** was called to question. (**Reauthorize subcategory priority order developed during 2003-2004 prioritization, with the addition of Outreach (MAI-funded) as the last item**). No one was opposed to calling to question. The Council voted on the motion (column 11 on attendance sheet) and the original motion passed.

Motion from the Co-chairs: The council requests that 30% of the current funding allocation within Outpatient Substance Abuse and Outpatient Mental Health Services be linked to programs meeting the definition of an Integrated Service Model. The council requests that these funds be directed towards services for African American and/or transgender clients.

Council Co-chair Geanuracos presented the motion. Council Member Simmons seconded the motion. The Council discussed the motion.

Council Member Shea stated **an amendment to add Residential Substance Abuse Services (HRSA Category-includes Detox, Residential, Crisis Mental Health) to the motion**. Council Member Johnson seconded the amendment. The Council discussed the amendment and voted (column 12 on attendance sheet). The amendment passed.

The **original motion as withdrew and then restated adding a language change:** **The Council requests that 30% of the current funding allocation within all Substance Abuse and all Mental Health Services be linked to programs meeting the definition of an Integrated Service Model. The Council requests that these funds be directed towards services targeting African American and/or transgender clients.** Council member Blum seconded this motion. The Council discussed this motion.

Public Comment:

A member of the Public commented that this motion would make a difference; these populations are the populations with the biggest gaps in services.

A second member of the public commented these are the most difficult populations to place and she would encourage the Council to clarify which transgender population.

The Council voted on the motion (column 13 on attendance sheet), and the motion passed.

Council Member Salle stated a **new motion to eliminate funding for subcategories 22-Integrated Case management, 23-Adult Day Health, 24-Treatment Adherence and move these dollars to the current ISM category, and then put these dollars out to bid for new or current ISPs, which must also include outpatient and mental health and substance use treatment**. Council Member Simmons seconded the motion. Council Member Salle explained the reasoning behind the motion. The Council then discussed the motion. This new motion would be for contracts to go into effect for March 1, 2004. **There was an amendment to apply just the Title I portion of the Treatment Adherence funds**. The motion was then withdrawn and restated. **The motion was resubmitted to include the amendment, to include only Title I funds for treatment**

adherence, within the motion. Council Members Simmons and Blum seconded the revised motion. The HIV Health Services staff did not think this could be possible for them to set up by the time required in the motion. Council Member Sallee withdrew the motion.

Council Member Hume stated **a motion to allocate 250K within Residential Substance Abuse Treatment for services to monolingual Spanish speaking clients.** Council Member Graham seconded the motion. The Council discussed the motion. Council Member Hume called the motion to question, Council Member Frazier was opposed to calling the question, then Council voted on calling the question (column 14 on attendance sheet). The call to question did not pass and there was more discussion after a dinner break.

XVI. DINNER

(Continued) XV. Service Category Allocations 2004-2005- VOTE

The Council **continued to discuss the motion to allocate 250K within Residential Substance Abuse Treatment for services to monolingual Spanish speaking clients.** It was mentioned that this would be the first time such a service would be offered to the Latino community in Spanish and assessments have shown if these services were offered they would be utilized. Council Member Antonetty called the motion to question. No one was opposed to calling the question.

Public Comment:

A member of the public spoke saying as a substance abuse provider she sees this problem with Spanish clients and can see why the Council should vote yes.

The Council voted on the motion to allocate 250K within Residential Substance Abuse Treatment for services to monolingual Spanish speaking clients (column 15 on attendance sheet). The motion passed.

Council Member Geanuracos stated **a motion to approve funding levels for all other service categories not covered in the previous motions, consistent with last years funding levels. This would include the MAI (Minority AIDS Initiative) funding level.** Council Member Siron seconded the motion. The Council discussed the motion. There was no public comment. The Council voted by a show of hands, three Council Members opposed the motion and 16 were in favor, therefore the motion carried.

XVII. Membership-VOTE

The Membership Committee presented a motion to approve the Council Members whose terms were up for renewal: Jeff Byers, Elyse Graham, Susan Shea, Kevin Johnson, Ken Pearce, and Mark Dunlop. The Council voted unanimously in favor of the motion.

The Membership Committee also presented a motion to approve two new candidates for Council membership: Cecelia Chung and Joe McMurray. The Council voted unanimously to approve the new members.

XVIII. Funding Scenarios –VOTE

Motion from the Planning Committee: Motion for the Council to adopt last year's funding methodology. Laura Thomas displayed the effects of various funding scenarios to the Council. The Council discussed the motion.

Public Comment:

A member of the public commented that if the subcategory Adult Day Health loses Ryan White funding, the program will be shut down.

The Council voted on the motion to adopt last year's funding methodology (column 16 on attendance sheet), and the motion passed.

XIX. Open Nomination for CO-Chairs

The Council opened nominations for Council co-chairs. The following Council Members were nominated:

Lara Salle
Brad Hume
Charles Siron
Anita Booker

Council Members Salle, Hume and Siron accepted their nominations. Council Member Booker said she would think about it and subsequently informed the Council that she had accepted the nomination.

Nominations will remain open until September 22, 2003 at the Council Meeting.

XX. Evaluation Committee

Council Member Allgaier informed the Council that the Evaluation committee will be sending out an evaluation of the prioritization process to each Council Member on September 3, 2003. This evaluation will be lengthy but please take your time and give comments. This will be used to make recommendations for next year's prioritization process. Each Council Member will be contacted if they did not return and evaluation.

XXI. New Business

There was no new business.

XXII. Adjourn

The meeting was adjourned at 7:22 p.m.

San Francisco

HIV Health Services Planning Council

City Hall, Mayor's Conference Room (Rm. 201)
1 Dr. Carlton B. Goodlett Place

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September 22, 2003

4:30 PM - 7:30 PM

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DRAFT AGENDA

- I. Call to Order 4:30 PM
- II. Roll Call 4:32 PM
- III. Review and Approval of Agenda 4:35 PM
- IV. Review and Approval of Minutes August 25, 2003 4:40 PM
- V. General Announcements 4:45 PM
- VI. Public Comment 4:50 PM
- VII. Budget for Inclusion with the 2004-2005 Grant Application- VOTE 5:00 PM

Laura Thomas

A brief presentation of the final budget that the SFDPH, HIV Health Services will include with the San Francisco EMA Grant Application for fiscal year 2004-2005.

Public Comment on this item

- VIII. HIV Prevention Goals 5:10 PM

Incorporating HIV Prevention goals into the Goals and Objectives.

Public Comment on this item

- IX. 500 K Add Back Recommendation- VOTE 5:30 PM

Vote on recommendation for spending the \$500, 000 add back from the Board of Supervisors.

Public Comment on this item

- X. Membership Committee Report & VOTE** **5:50 PM**
Membership Committee report and vote on new membership candidate, Nona Nangalama.
Public Comment on this item
- XI. Dinner Break** **6:00 PM**
- XII. Council Committee Reports** **6:15 PM**
- | | |
|--|-------------|
| Infrastructure & Policy Committee | 6:15 |
| Evaluation Committee | 6:20 |
| Planning Committee | 6:25 |
| Community Outreach and Advocacy | 6:30 |
- XIII. Report on HRSA Requirements for Unmet Need** **6:35 PM**
Joe Fera and Laura Thomas
A report back from the recent HRSA Title I and Title II regional technical assistance meeting on unmet need.
Public Comment on this item
- XIV. AIDS Office Contract Monitoring** **6:45PM**
Michelle Long Dixon
Quarterly Report from Michelle Long Dixon, Director HIV Health Services
Public Comment on this item
- XV. CAEAR Coalition Public Policy Update** **6:55 PM**
Lara Salle
Public policy update and report from the CAEAR Coalition meeting, including an update on appropriations for FY 2004 and 2005, and CARE reauthorization.
Public Comment on this item
- XVI. ADAP/Medi-Cal Update** **7:05 PM**
Jeff Byers
Monthly update on recent ADAP/Medi-Cal developments.
Public Comment on this item
- XVII. Co-chair Elections** **7:15 PM**
Close of Co-chair nominations. Distribute and collect ballots.
Public Comment on this item
- XVIII. New Business** **7:25 PM**

XIX. Next Agenda

7:27 PM

XX. Adjourned

7:30 PM

Note: Agenda items are subject to change, postponement, or removal. Meeting agendas are considered to be in DRAFT form until reviewed and approved by Committee attendees.

*HIV Health Services Planning Council
730 Polk Street San Francisco, CA 94109*

*San Francisco Department of Public Health, AIDS Office
25 Van Ness Avenue, 5th floor, San Francisco, CA 94102*

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HIV Health Services Planning Council

**City Hall, Mayor's Conference Room (Rm. 201)
1 Dr. Carlton B. Goodlett Place**

**September 22, 2003
4:30 PM - 7:30 PM**

DRAFT MINUTES

I. Call to Order

The meeting was called to order at 4:35 p.m.

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II. Roll Call

See attachment A for Roll Call.

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III. Review and Approval of Agenda

The agenda was approved by consensus. A list of all the up-coming Committee meetings will be listed at the end of the Council Meeting agenda in the future.

IV. Review and Approval of Minutes August 25, 2003

The minutes from the August 25, 2003 Council Meeting were approved by consensus. Council Member (CM) Sanders abstained from voting to approve the minutes.

V. General Announcements

CM Tanner announced he received a letter from the Membership Committee regarding participation. He requested that the Committee meeting schedule for the month be listed on the Council Meeting agenda.

CM Booker reminded the Council to please fill out the evaluation survey and turn them in to Council Support as soon as possible.

CM Hume announced on Tuesday, September 30, 2003 from 4:00-6:00 p.m. at the Bayview Opera House (4705 3rd Street @ Oakdale), the HIV Prevention Planning Council will be hosting a Community Forum. The results of Bayview/Hunter's Point SCAN research (Systems Capacity Assessment by Neighborhood) will be presented for discussion.

CM Hume also announced the Mayor has chosen not to re-appoint Mark Dunlop to the Council. The Co-chairs of the Council will write a letter to the Mayor's office expressing disappointment. There is an expectation we will need to resubmit his name to the new Mayor, when he takes office.

Joe Fera announced a list of Council Member contact information will be passed around and if all Council Members could check their information and make any changes it would be much appreciated. Also, please remember to help Council Support leave this room as we found it, put all trash in trashcans and be considerate of the space.

Joe Fera also announced there will be a new member orientation on Thursday, October 2, 2003.

VI. Public Comment

Jim Illig (Project Open Hand) announced a Mayoral Candidates Forum on Thursday, September 25, 2003 from 6:00-8:00 p.m. at the McLaren Center, University of San Francisco. He encourages everyone to attend. This announcement was also sent out on the Yahoo! Group.

Mark Dunlop announced he has been a member of the Council for seven years and has given it his heart. He had a disagreement with the Mayor two years ago and is hoping the Mayor will reconsider his decision to not reappoint him to the Council. He thanked the Co-chairs for writing a letter and hopefully he will be re-appointed in January, 2004.

Patrick Monette- Shaw submitted his written comment:

Jim Illig just testified he attended a recent Alameda council meeting where that body deliberated for three days over prioritizing HIV/AIDS services. Illig noted Alameda receives one-sixth (approximately \$6 million) of the funds as does San Francisco, yet they took three full days, as opposed to one day retreat, to prioritize services. Illig noted he wished a Patrick Monette-Shaw had been present to ask why Alameda hired a harpist for entertainment. I see I'm making an accountability contribution to the San Francisco EMA, since this Council has not wasted funds intended for people with HIV/AIDS by hiring harpists here.

Council member Mark Dunlop also announced Mayor Brown had not reappointed Dunlop to another term on this Council. Brown's vindictiveness knows no bounds; his pettiness not reappointing Dunlop is a disservice to people with HIV/AIDS. When you write Brown seeking clarification, point out that his vindictiveness affects innocent people with HIV/AIDS.

VII. Budget for Inclusion with the 2004-2005 Grant Application- VOTE

Laura Thomas (HIV Health Services) distributed the budget for the HRSA Title 1 grant application to the Council and explained that she needs the Council's approval of the application budget. This budget is for a greater amount than the EMA will receive, and because of that has no real consequences. The first column shows the current fiscal year and the next set of columns show 2004. CM Sanders stated a motion to vote on the grant budget and CM Pugh seconded the motion. The Council voted by a show of hands and the motion carried.

VIII. HIV Prevention Goals

CM Geanuracos handed out the Proposed Goals for HIV Prevention for Inclusion in the 2004-05 Grant Application. She went over each of the goals listed:

1. Develop and approve a definition of "Prevention for Positives" in collaboration with the HIV Prevention Planning Council
2. Encourage CARE-funded providers, especially primary care providers, to enroll staff in HIV Prevention trainings and in-services.
3. Encourage CARE-funded agencies to apply for HIV prevention funding opportunities.
4. Explore the feasibility of including HIV prevention services as a component of the Integrated Services Model.
5. Increase coordination with the HIV Prevention Planning Council of needs assessment, community outreach, and quality management initiatives. Conduct biannual joint working meetings with the HPPC.

CM Hume mentioned the terminology is Prevention **with** Positives. CM Hume motioned to adopt these goals into the goals and objectives of the Council. CM Sanders seconded the motion. The Council voted by a show of hands and the motion carried, unanimously.

IX. 500 K Add Back Recommendation- VOTE

CM Hume explained the history of the 500 K add back. CM Geanuracos stated the Steering Committee put forward a motion to allocate the 500K to the top tier of services, allowing the AIDS office to decide what fiscal year the funds are placed into. The Council then discussed this motion.

Public Comment

Jim Illig (Project Open Hand) explained a detailed history of the funds from the Board of Supervisors 500K add-back.

Russ Zeller (HIV Health Services- AIDS Office) explained that the proposals from providers for Unfunds were not connected to the general fund, and are really to be used for Unfunds.

Patrick Monette- Shaw submitted his written comment:

The Steering Committee's recommendation for spending the \$500,000 add back from the Board of Supervisors is flawed. The Supervisors indicated the funds were to backfill lost federal CARE Act funds. This is **not** new, unexpected money to do with as you please, as Co-chair Hume just suggested. The Council chopped all service providers two years ago, reportedly with an across-the-board 6% cut (we all know the 6% was not applied across-the-board; some agencies were cut more, some less). The add back may be from General Funds, but the Supervisors intended to restore lost federal funds; as such, it should be returned equitably to **all** providers cut in 2001. Mitch Katz and Jimmy Loyce are the grantees; this Council should be directing them to restore the funds to all providers, not just to the top 11 service category priorities, particularly since the priority ranking was developed after the cuts were made.

The Council then voted on the motion to allocate the 500K to the top tier of services and allowing the AIDS office to decide into what fiscal year the funds are placed (See attachment A). The motion carried.

X. Membership Committee Report & VOTE

CM Rodriguez gave a report from the Membership Committee. He announced that in September all Council Members can chose to change their home committees or stay on their current committees. Please contact Council Staff if you are choosing a new committee or staying on your current committee. If a Committee is full please chose a different committee and anyone who has not chosen a committee by the end of September will be assigned to one by the Membership Committee. New Members do not need to choose a committee at this time and will receive more information at their orientation. The Membership Committee was happy to announce they have reached their goal for Latino representation on the Council. Two new Membership nominees were brought forward to the Council from the Committee. The nominees were: Nona Nangalama and Alison Clayton. The Council voted all in favor of the new members.

CM Hume also announced that CM Riker is no longer on the Council and she was the representative for the formerly incarcerated. Therefore, the Council needs a representative for this community. CM Graham mentioned she also works in the County jails, and will try to represent this community in the

future and will help to recruit someone to fill this position on the Council. CM Chung reminded the Council to actively recruit a representative from the Bayview-Hunters Point area.

XI. Dinner Break

XII. Council Committee Reports

Infrastructure & Policy Committee

CM Pugh encouraged Council Members to sign up for the Infrastructure and Policy Committee. At the next meeting they will be discussing the draft of the Memorandum of Understanding between the Council and the AIDS Office. The Committee meets on the first Wednesday of each month at 5:30 p.m. and their work includes the Grantee Assessment and the Council calendar.

Evaluation Committee

CM Booker announced that the Evaluation Committee's current main objective is to collect all the evaluation forms from Council Members. She asked all Council Members to please turn in their evaluation forms within the next three days if they have not done so already. The forms can be turned into Council Staff. She also announced there was a grievance filed with the Council and this has been passed on to the Evaluation Committee, who will hold a hearing at the next Committee meeting on Monday, October 6, 2003 from 5:00-7:00 p.m. at 25 Van Ness, room 330A. The Committee is charged with evaluating the implementation of the current priorities and assessing the impact of Council decisions.

Planning Committee

CM Shea announced the Planning Committee has been working on their mission statement. The Committee sees itself as the future oriented committee, which plans prioritization and the Needs Assessments. In the next couple of months the Committee will be evaluating decision making models from other Councils and will have the first prioritization vote on the January 2004 agenda. The Committee meets on the second Tuesday of each month from 3:30-5:30 p.m.

Community Outreach and Advocacy

The Community Outreach and Advocacy Committee did not meet in September.

XIII. Report on HRSA Requirements for Unmet Need

Laura Thomas (HIV Health Services) handed out the document, the Ryan White CARE Act Title I and II Regional Technical Assistance Meeting on Unmet Need (page 6 is a good summary). The Council is charged with the task of figuring out how many people are not in CARE and how to get them into CARE, right now the Council will need to focus on who these people are and how many people there are. This population is comprised of people who know they are positive but are not in medical care, this is HRSA's unmet need definition. The data for this project is not always available or complete, and at this time HRSA has asked for: a framework for finding this data information and how to make an estimate of unmet need. The SF Health Department is working with UCSF on this project and the project will include representatives from San Mateo and Marin Counties and representation from the Council. For the grant application this year HRSA requires a timeline and next year they expect the EMA to have an estimate of unmet need. The Council then discussed the unmet need project and Laura Thomas mentioned she would be happy to answer any questions about the project and if any Council Members are interested in being a part of the project, please contact her.

Patrick Monette- Shaw submitted his written comment:

During Laura Thomas' excellent summary of the HRSA meeting on unmet needs, she noted rightfully that Congress failed allocating additional funding for bringing HIV-positive people who are not currently in care into healthcare services. I suggest that this Council reopen tonight's Board of Supervisors add back motion and last month's "unfunds" motion, and possibly reconsider allocating a portion of the combined \$1.2 million (between unfunds and the add back) for use in identifying those not in care and subsequently getting them into HIV/AIDS healthcare. After all, you can't keep allocating all unexpected funding to the top eleven service categories in Tier 1 *ad nauseum* without setting aside a portion of those funds to address Congress' mistake in not allocating additional funding to bring people into care. How will this Council fund getting these people into care if you continue fattening up the top 11 service categories every chance you get?

XIV. HIV Health Services Quarterly Report

Michelle Long Dixon (HIV Health Services) handed out the 2nd Quarterly Report to the Council. She then reviewed the information on the report. For more information, please see the meeting handouts or audio recording.

XV. CAEAR Coalition Public Policy Update

CM Sallee gave a CAEAR Coalition update to the Council. She announced Congress has put no additional money into Title I, and Title 3 funding, which goes directly to Community Clinics, is going to receive a small cut in funding. The CAEAR Coalition is starting to discuss 2005 and by mid-October may have some budget numbers. The CAEAR Coalition works year round on Title 1 and Title 3, and on the five-year reauthorization process of the entire CARE Act. The current administration would like to get involved in the writing of the reauthorization, so the CAEAR Coalition is discussing the possible affects this may have on the process and the CARE Act. CM Allgaier is the Mayor's representative on the CAEAR Coalition. Laura Thomas (HHS) mentioned it is important for the Council to be aware of what is happening at the National level and the impact of National politics on the CARE Act.

Patrick Monette- Shaw submitted his written comment:

Council member Lara Salle reported this is the first year Congress has not added new funding for Title I and Title III of the CARE Act since it was first authorized, and that Congress' failure to do so has resulted in flat funding this year. I note with interest that during Nancy Pelosi's inaugural swearing-in as a U.S. House of Representatives member, she announced she was there to fight AIDS as her number one priority. If that is the case, where was Pelosi's leadership, and why was she unable to secure increased CARE Act funding this year? Tom Coburn managed to get over 250 bipartisan House members to co-sponsor his CARE Act Reauthorization bill in 2000. If Coburn could achieve that level of support, why hasn't Pelosi been capable of securing additional CARE funding this year? This Council needs to question Pelosi to find out why she failed so miserably.

XVI. ADAP/Medi-Cal Update

There was no ADAP/Medi-Cal update this month.

XVII. Co-chair Elections

The nominations for Council Co-chairs were closed and ballots were distributed to all Council members. The Council was reminded of the goal in the by-laws: at least one co-chair must be a

woman, a person living with HIV, and a person of color. Joe Fera collected the ballots and CM Anita Booker, CM Brad Hume, and CM Lara Salle were voted the new Council Co-chairs.

XVIII. New Business

There was no new business.

XIX. Next Agenda

XX. Adjourned

The meeting was adjourned at 7:22 p.m., with some Council members remaining to hear the co-chair election results.

- See Previous

HIV Health Services Planning Council

City Hall, Mayor's Conference Room (Rm. 201)
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October 27, 2003
4:30 PM - 7:30 PM

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|--|----------------|
| I. Call to Order | 4:30 PM |
| II. Roll Call | 4:32 PM |
| III. Review and Approval of Agenda | 4:35 PM |
| IV. Review and Approval of Minutes- September 22, 2003 | 4:40 PM |
| V. General Announcements | 4:45 PM |
| VI. Public Comment | 4:50 PM |
| VII. Training-<i>Robert's Rules of Order</i>
Travis Barrick, JD, MPA, PRP
<i>Basic training session for Council members in parliamentary procedure: motions, amendments, voting, debate, etc.</i>

<i>Public Comment on this item</i> | 5:00 PM |
| VIII. Discuss Draft MOU
<i>Infrastructure and Policy Committee brings forward the draft Memorandum of Understanding (MOU) between the AIDS Office and the Council for discussion.</i>

<i>Public Comment on this item</i> | 5:48 PM |
| IX. Dinner Break | 6:03 PM |
| X. Topics for Prioritization- VOTE
<i>The Planning Committee presents the topics for 2005-2006 Prioritization Process and requests Council vote of approval.</i>

<i>Public Comment on this item</i> | 6:18 PM |

XI. Council Training Needs Assessment

6:53 PM

Joe Fera

Announcement of Council Training Needs Assessment, explanation of the process involved and Council Member participation.

Public Comment on this item

XII. Membership-VOTE

7:03 PM

The Membership Committee will forward their recommendation to reappoint Catherine Geanuracos to the HIV Health Services Planning Council for a term of two years commencing November 1, 2003.

Public Comment on this item

XIII. Council Committee Reports

7:08 PM

Membership Committee	7:08
Infrastructure & Policy Committee	7:11
Evaluation Committee	7:14
Community Outreach and Advocacy	7:17

XIV. ADAP/ Update

7:20 PM

Randy Allgaier

Monthly update on recent ADAP/Medi-Cal developments.

Public Comment on this item

XV. New Business

7:22 PM

XVI. Next Agenda

7:25 PM

XVII. Celebration & Thanks

7:27 PM

XVIII. Adjourned

7:30 PM

HIV Health Services Meeting Schedule

November

(tentative dates and meeting locations)

Evaluation Committee	Monday, November 3rd	5:00– 7:00 p.m	25 Van Ness Ave., Rm. 330 B
Membership Committee	Monday, November 10th	4:30- 6:30 p.m.	25 Van Ness Ave., Rm. 330 B
Planning Committee	Tuesday, November 11th	3:30- 5:30 p.m.	25 Van Ness Ave., Rm. 330 B
Community Outreach and Advocacy Committee (NOTE: change in date and time)	Wednesday, November 12th	4:30-6:30 p.m.	25 Van Ness Ave., Rm. 330 B
Steering Committee	Monday, November 17th	5:00 - 6:30 p.m	25 Van Ness Ave., Rm. 330 B
Infrastructure & Policy Committee (NOTE: change in date and time)	Wednesday, November 19th	5:30 - 7:00 p.m	25 Van Ness Ave., Rm. 330 B
HIV Health Services Planning Council Meeting	Monday, November 24th	4:30- 7:30 p.m.	City Hall, Mayor's Conf. Rm 201

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*HIV Health Services Planning Council
730 Polk Street San Francisco, CA 94109*

*San Francisco Department of Public Health, AIDS Office
25 Van Ness Avenue, 5th floor, San Francisco, CA 94102*

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San Francisco

HIV Health Services Planning Council

City Hall, Mayor's Conference Room (Rm. 201)
1 Dr. Carlton B. Goodlett Place

October 27, 2003
4:30 PM - 7:30 PM

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I. Call to Order

The meeting was called to order at 4:38 p.m.

II. Roll Call

See attachment A for Roll Call.

III. Review and Approval of Agenda

The agenda was approved by consensus.

IV. Review and Approval of Minutes- September 22, 2003

The minutes from the September 22, 2003 Council Meeting were approved by consensus.

V. General Announcements

Council Co-chair (CC) Booker announced that the Council Co-chairs received a response from Mayor Brown regarding the refusal to re-appoint Mark Dunlop to the Council. The Mayor stated he would like to give someone else the opportunity to serve on the Council.

CC Hume welcomed CC Booker and CC Salle as Co-chairs and announced that at each meeting the Council Co-chairs will have a different role, as meeting facilitator, time keeper and recording the speaker's list. He also announced there is an updated document on meeting procedures that includes more information regarding public comment. At the discretion of the Council Co-chairs, members of the public may be asked to give clarification to the Council and for each agenda item there will be a designated amount of time for public comment. The Council encourages members of the public wishing to speak to submit a speaker's card to the Co-chairs.

Council Member (CM) Pearce recommended stapling a speaker's card to the Meeting Procedures document and creating a small sign stating, if you wish to have public comment please fill out a card.

CM Allgaier announced there is an evaluation of the Council Meeting for each Council Member present to fill out. The Evaluation Committee is asking that at each meeting Council Members give their feedback.

Joc Fera announced the Planning Committee will be meeting on Thursday November 13, 2003 from 4:00-6:00 p.m. at 25 Van Ness in room 330B this month. Also, the Community Outreach and Advocacy Committee has a new meeting time, on the second Wednesday of the month from 4:30-6:30

p.m. The Infrastructure and Policy Committee will be meeting on Wednesday November 19, 2003 from 5:30-7:00 p.m., please note: the meeting date for Infrastructure and Policy has changed for this month only.

CM Geanuracos announced there will be a Partnerships for Youth Symposium on Friday, November 7, 2003 from 9:00am until 5:00pm., hosted by the San Francisco Lesbian, Gay, Bisexual and Transgender Community Center located at 1800 Market Street, San Francisco. In addition, there is a new clinic opening in Oakland and if you would like more information please contact CM Geanuracos.

VI. Public Comment

Patrick Monette-Shaw submitted his written comment:

I encourage this Council to re-submit Mark Dunlop's name for membership on the HIV Health Services Planning [a.k.a., "CARE"] Council to our next Mayor next January on the day after our next mayor is sworn into office. Mayor Brown's agenda seems to be all about whether or not he is afforded sufficient levels of respect to support his ego, and as Supervisor Daly noted during last week's flap while Mayor Brown was in Tibet, everything is about Willie, not about whether the people he appoints to oversight bodies care about the needs of San Francisco residents, or people with HIV/AIDS.

It will be a disappointment to have a respected advocate like Dunlop off of this Council for several months, but I ask that the Co-Chairs prepare and submit a recommendation before January 8th asking that our next Mayor reappoint Mr. Dunlop to this advisory body immediately.

Public Comment:

Bill Hirsh (AIDS Legal Referral Panel) is promoting a Hearing on Housing Issues for People with Disabilities Thursday, October 30, 2003 at 10:00 a.m. in City Hall , room 263. Anyone is welcome to come and testify. The idea of the hearing is to educate decision makers about issues around housing for people with disabilities. Mr. Hirsch also asked if there was any information from the AIDS Office about the timeline for new contracts.

VII. Training-Robert's Rules of Order

Travis Barrick, JD, MPA, PRP presented a training session for Council Members in parliamentary procedure. For more information, please refer to the handout of the meeting presentation or the audio recording.

Public Comment on this item

Patrick Monette-Shaw submitted his written comment:

While the honorable Parliamentarian Barrick clearly knows his material better than I, I was tempted to claim "point of order" during presentation of his slide titled "Sunshine Regulations."

Parliamentarian Barrick may want to check with City Attorney Ann Alpers, if I remember he name correctly, who just recently trained this Council on Sunshine stipulations. She advised this Council recently to be very careful not to use e-mail to discuss subject matters before this Council. I raised this very question to Ms. Alpers during her presentation to correct Mr. Barrick's previous presentation to this Council when he told falsely advised e-mail communications were permitted.

I advise Parliamentarian Barrick to check with the City Attorney before he presents this Robert's Rules of Order advice to other City agencies, such that he does not continue to advise regulatory bodies by countermanding advice the City Attorney's office is most appropriately better qualified to dispense.

VIII. Discuss Draft MOU

CC Hume introduced the draft Memorandum of Understanding (MOU) and explained that the general intent of the document is to outline the roles and responsibilities of the Council and the Grantee. CM Pugh explained the MOU was set up to be reviewed annually. The MOU is divided into sections describing the Council and the Grantee's activities. The Conflict Resolution section is an attachment to the MOU document. CM Pugh thanked Laura Thomas, Michelle Long Dixon, the Infrastructure and Policy Committee and Joe Fera of all their work on completing this document.

The Council discussed the MOU. It was recommended that this document be reviewed annually. It was mentioned that perhaps quality management be looked at for inclusion to the document in the future. CM Pugh mentioned if any Council Members have addition feedback please come to the next Infrastructure and Policy Committee meeting on Wednesday, November 19, 2003 at 5:30 p.m. At the next Council Meeting (November 24, 2003), the Council will vote on the adoption of the MOU.

There was no public comment.

IX. Dinner Break

X. Topics for Prioritization- VOTE

CM Shea presented the list of topics for prioritization. (The vote on 1.5-2 hours at each meeting used for prioritization and the vote on the meeting and retreat dates will be at the November Council Meeting.) CM Shea explained the Planning Committees ideas for prioritization, for further information on the presentation please refer to the handouts or the audio recording.

The Council discussed the motion to adopt the list of topics for prioritization. An amendment was added to include Epidemic and surveillance data, and the separation of number three (3) needs assessment, making number four (4) Consumer input a separate item. The Council voted all in favor of the motion to adopt the list of topics for prioritization. Please see the complete list below. A timeline for these topics will be voted on at a later date.

List of topics for Prioritization 05-06

Pending vote 10.27.03 by Council

1.	HRSA Program Guidance
2.	3 year plan
3.	Needs Assessments: HIV out of care
4.	Consumer Input
5.	Ability of providers to replace CARE monies
6.	Core Services Definition
7.	Reggie Data
8.	Summary sheets on subcategories
9.	Ethical decision making
10.	Shared Values
11.	Input from prioritization 04-05
12.	Reports from Counties
13.	ISM Definition

14. What decision making model should we use?
15. Severe need definition
16. Funding scenarios
17. Rebidding process and how it affects prioritization and vice versa
18. Prioritizing categories and subcategories
19. Provider input
20. Budget
21. Eligibility for services
22. Ryan White CARE Act model in SF: with input from HIV Health Services, Providers and Consumers
23. Overall structure of HIV Care in SF: structure and finances
24. Cost effectiveness and outcome effectiveness data
25. HIV Prevention and the prevention and treatment of substance use and the coordination with CARE services
26. MAI program need for capacity building in historically underserved populations.
27. Conflict of Interest training
28. Epi & Surveillance Data

XI. Council Training Needs Assessment

Joe Fera introduced the Training Needs Assessment. Two separate tools have been developed for the needs assessment, one tool is for all Council Members to fill out and the other is for Council and Committee Co-chairs to fill out along with the general Council Member assessment. The assessment will also include a couple of focus groups to look at specific topics. The goal is to have the training needs assessment completed by the next Council Meeting and report back to the Council with a training plan at the November 24, 2003 Council Meeting. All Council Members were asked to please turn in their Training Needs Assessment form by November 10, 2003.

XII. Membership-VOTE

The Membership Committee forwarded their recommendation to reappoint CM Catherine Geanuracos to the HIV Health Services Planning Council for a term of two years commencing November 1, 2003. The Council voted and unanimously approved the reappointment of CM Geanuracos.

XIII. Council Committee Reports

Membership Committee

CM Rodriguez announced the new Committee Co-chairs are CM Rodriguez and CM Sanders. The Committee is currently working on the Membership Policies and Procedures, membership recognition activities, Committee assignments, and a Committee calendar.

Infrastructure & Policy Committee

CM Pugh reminded the Committees to please submit their Committee calendar to Council Support by November 17, 2003. At the next Infrastructure and Policy meeting, the Committee will be creating the Master Calendar and looking at un-obligated funds. The Committee is now meeting for an hour and a half at each meeting. The next Infrastructure and Policy Committee meeting will be on Wednesday, November 19, 2003 from 5:30-7:00 p.m.

Evaluation Committee

CM Allgaier encouraged Council Members to turn in their evaluations of prioritization, if they have not done so already. He also encouraged everyone to please turn in the meeting evaluation at the end of each Council Meeting. At the last Evaluation Committee meeting they heard the grievance filed with the Council, and at their next Committee meeting on November 3, 2003 from 5:00-7:00p.m., the Committee will discuss the draft response to the grievance. A formal response is required within 60 days of the proceeding and will be presented to the Full Council at the November meeting for a vote. CM Allgaier and CM Flood were voted the new Evaluation Committee Co-chairs.

Community Outreach and Advocacy

CM Durio announced that himself and CM Geanuracos were elected as the Committee's Co-chairs. The Committee has been working on calendar development and brochures for the HIV Health Services Planning Council and the Consumer Rights Advocacy Project. The Committee also has several new members and will discuss whether to change the Committee's meeting time at its next meeting on Wednesday, November 12, 2003 from 4:30-6:30 p.m.

XIV. ADAP/ Update

CM Allgaier gave a brief ADAP update. He mentioned there is not anything new to report but at this time, there is a question about what Governor Schwarzenegger will decide for the state budget. The Governor has hired an auditor, who is famous for cutting Health and Human Services budgets. CM Allgaier urged the Council to be aware of this over the next couple of months.

XV. New Business

There was no new business mentioned.

XVI. Next Agenda

Possible items to include on the next agenda:

- Report on the Training Needs Assessment
- Vote on the Memorandum of Understanding (MOU)
- Evaluation Committee's Grievance recommendation

XVII. Celebration & Thanks

The Council wishes to thank Laura Thomas for her dedication and work with the Council.

XVIII. Adjourned

The meeting was adjourned at 7:20 p.m.

San Francisco

HIV Health Services Planning Council

City Hall, Mayor's Conference Room (Rm. 201)
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4:30 PM - 7:30 PM

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DRAFT AGENDA

- I. Call to Order 4:30 PM**
- II. Roll Call 4:32 PM**
- III. Review and Approval of Agenda 4:35 PM**
- IV. Review and Approval of Minutes- October 27, 2003 4:40 PM**
- V. General Announcements 4:45 PM**
- VI. Public Comment 4:50 PM**
- VII. Presentation- San Francisco Sunshine Ordinance 5:00 PM**

Rick Sheinfeld, Attorney

Rick Sheinfeld, an Attorney for the City of San Francisco, will provide a presentation to Planning Council members regarding the San Francisco Sunshine Ordinance as it pertains to the Planning Council. The presentation will include discussion on specific areas of the law pertaining to open meetings, agendas, minutes, public comment, etc.

Public Comment on this item

- VIII. Grievance Response- VOTE 5:20 PM**

The Evaluation Committee presents their response to the grievance filed with the Council for Council approval.

Public Comment on this item

- IX. Council Training Needs Assessment 5:35 PM**

Joe Fera

Presentation of Council Training Needs Assessment results and new training plan for the Council.

Public Comment on this item

X. ADAP/Medi-Cal Update

5:45 PM

Jeff Byers

Monthly update on recent ADAP/Medi-Cal developments.

Public Comment on this item

XI. Thank You

5:50 PM

The Council wishes to recognize and thank Laura Thomas.

Public Comment on this item

XII. Dinner Break

6:00 PM

XIII. Planning Committee Prioritization Process- VOTE

6:15 PM

The Planning Committee presents the following two motions for the 2005-2006 Prioritization Process and requests Council vote of approval.

- 1. To dedicate one to one and a half hours at each Council Meeting for Prioritization Activities.*
- 2. To begin prioritization in October meeting monthly, with two meetings in June and one 8 hour meeting in July, 2004.*

The Committee will also present the draft calendar of prioritization topics to be covered at each Council meeting (no vote).

Public Comment on this item

XIV. Decision Making Presentation

6:30 PM

John Golenski

A discussion of ethical decision-making incorporating the Shared Values and Vision from the Three Year Plan.

Public Comment on this item

XV. AIDS Office Re-bidding Process Update

7:20 PM

Michelle Long Dixon

Monthly update on the HIV Health Services/ AIDS Office Contract Re-bidding Process.

Public Comment on this item

XVI. December Council Meeting-VOTE

7:25 PM

Vote on not holding a December 2003 HIV Health Services Council Meeting.

Public Comment on this item

XVII. Next Agenda

7:27 PM

XVIII. Adjourned

7:30 PM

December

(tentative dates and meeting locations)

Evaluation Committee	Monday, December 1st	5:00 - 7:00 p.m	25 Van Ness Ave., Rm. 330 A
Infrastructure & Policy Committee	Wednesday, December 3th	5:30– 7:00 p.m	25 Van Ness Ave., Rm. 330 A
Membership Committee	Monday, December 8th	4:30- 6:30 p.m.	25 Van Ness Ave., Rm. 330 A
Planning Committee	Tuesday, December 9th	3:30- 5:30 p.m.	25 Van Ness Ave., Rm. 330 A
Community Outreach and Advocacy Committee	Wednesday, December 10th	4:30-6:30 p.m.	25 Van Ness Ave., Rm. 330 A
Steering Committee	Monday, Dccember 15th	5:00 - 6:30 p.m	25 Van Ness Avc., Rm 330 A
HIV Health Services Planning Council Meeting	Monday, December 22th	4:30- 7:30 p.m.	City Hall, Mayor's Conf. Rm 201

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HIV Health Services Planning Council

**City Hall, Mayor's Conference Room (Rm. 201)
1 Dr. Carlton B. Goodlett Place**

**November 24, 2003
4:30 PM - 7:30 PM**

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DRAFT MINUTES

I. Call to Order

The meeting was called to order at 4:35 p.m.

II. Roll Call

See attachment A for Roll Call.

III. Review and Approval of Agenda

The agenda was approved by consensus.

IV. Review and Approval of Minutes- October 27, 2003

The minutes from the October 27, 2003 Council Meeting were approved by consensus.

V. General Announcements

Council Member (CM) Allgaier announced an update on the Medicare legislation. The final version approved by the House/Senate conference committee has a provision that will cause more harm for people with HIV/AIDS than the benefits it would provide. The provision would eliminate "wrap-around" drug coverage for 6 million people who are eligible for Medicaid and Medicare (known as "dual-eligibles"). These are the sickest and poorest seniors and people with disabilities, including 50,000 people with AIDS. (Please see the email to the Yahoo! group on November 24, 2003 for more information.) Senator Feinstein has come out in support of this bill. CM Allgaier urged everyone to contact Senator Feinstein and encourage her to oppose this legislation.

CM Hume announced that the Council Meeting Procedures are at the table by the door. He just wanted to reiterate that public comment is not a time to ask questions, and the Council will not answer any questions from public comment. The Council also asks that public comment be addressed in a respectful and considerate manner and the Council Co-chairs will be reinforcing that the meeting procedures are followed and applies consistently.

Joc Fera announced, the Marin County Department of HIV Health Services is scheduling site visits on December 18, 2003 from 1:30-3:30 in the afternoon. They would like to have some unaffiliated consumers participate in the process. If any Council Members are interested please contact Council Support for further information.

VI. Public Comment

Bill Hirsh (AIDS Legal Referral Panel) announced that the AIDS Legal Referral Panel recently subcontracted with the Bar Association for an immigrant legal assistant program. They are hosting an open house on Wednesday, December 10, 2003 and all are welcomed.

Kelly Wallace announced he was present at the meeting as a Marin County Aids Office representative, but not as a council member, for the Council Meeting this evening.

Patrick Monette-Shaw submitted his written comment:

HRSA's CARE Advisory Committee met November 20 recommending the 10% administrative cap on CARE awards for administrative overhead be increased to 20% to 30%.

At issue: If this targets the whole EMA, increasing the amount the grantee keeps for administration to 30% could completely eliminate 17 of San Francisco's service category priorities, including transportation, home care and residential substance abuse treatment. If at our ASO level, primary medical care services to people could drop by \$1.4 million, and residential programs and housing subsidies could drop by \$1.6 million.

For PLWH/A lacking access to medications, it's outrageous AIDS bureaucrats would place money-lust above needs of people seeking access to medications and housing.

You are Council members to advocate for CARE *clients*, not providers' administrative interests. How many people will languish on waiting lists because people like Pat Christen seek to fatten up organizational overhead? I urge you to oppose this recommendation.

VII. Presentation- San Francisco Sunshine Ordinance

Rick Sheinfeld, from the City Attorney's office, gave a presentation on the Sunshine Ordinance and how the ordinance applies to the Council. For more information regarding this presentation, please refer to the handouts or the audio recording.

VIII. Grievance Response- VOTE

CM Allgaier presented the Evaluation Committee's response to the grievance filed with the Council and a motion to discharge the grievance with no further action. For more information regarding this presentation, please refer to the handouts or the audio recording. The Council then discussed the motion.

Public Comment on this item

Mark Cloutier (Continuum) commented he would like to refocus on cost effectiveness, and agreed this data was not available to the Council. But of the data available, there is evidence of increased emergency room use among certain populations. He also clarified the conflict of interest issue, there are Council Members, who run agencies that directly benefit from Council decisions and do not exclude themselves from voting on matters, which may benefit the agency. Lastly, Mr. Cloutier thanked CM Allgaier and the Evaluation Committee for their thoughtfulness and respect for the grievance process.

The Council voted on the motion to discharge the grievance (Please see attachment A, column 2 for Council Member voting record). The motion passed unanimously.

IX. Council Training Needs Assessment

Joe Fera gave a brief update on the Council Training Needs Assessment. Thirteen surveys have been received so far, if any other Council Members still has their survey, Council Support would be happy to receive them. It would especially be helpful to receive the surveys from Council and Committee Co-chairs. Carol Kleinmeier is working on the results of the assessment and will present these at the Evaluation Committee meeting on Monday, December 5, 2003 from 5:00-7:00 p.m. at 25 Van Ness, room 330. Council Support would appreciate as much input and involvement in this process as possible. Thank you to all Council Members who have participated.

X. ADAP/Medi-Cal Update

CM Byers gave an update on recent ADAP and Medi-Cal developments. He reported there have been reductions from the state and this has had an affect on the State AIDS Office. It is possible there will be further reductions. One of the affects of the reductions is they want to decrease travel, so this appointment to the Council, which CM Byers fills, might be reduced to attending about six meeting per year.

Public Comment on this item

Laura Thomas commented, Senator Feinstein has indicated she is going to vote for this bill and as the current bill is written this will actually harm people living with AIDS who are dual eligible, if passed they would be limited to very partial drug benefits. Please call Senator Feinstein and urge her to vote against this bill.

XI. Thank You

The Council and Council Co-chairs thanked Laura Thomas for all her work and dedication during her tenure with the Council.

XII. Dinner Break

XIII. Planning Committee Prioritization Process- VOTE

CM Shea presented the following two motions brought forward to the Council from the Planning Committee.

- 1. To dedicate one to one and a half hours at each Council Meeting for Prioritization Activities.*
- 2. To begin prioritization in October meeting monthly, with two meetings in June and one 8 hour meeting in July, 2004.*

CM Shea stated an amendment to change the first motion to say, due to a typo:

- 1. To dedicate one and a half to two hours at each Council Meeting for Prioritization Activities.*

The amendment was seconded. The Council voted on the amendment and the amendment passed.

The Council then voted by a show of hands on the first motion as amended. The first motion passed.

The Council discussed the second motion. CM Hume spoke in favor of the second motion but mentioned when people sign onto the Council, extra meetings are not part of the requirement. People

need to understand this as part of the membership requirements. The Council voted on the second motion. The second motion also passed.

CM Blum mentioned the Planning Committee would like all Council Members to please look over the draft Calendar for Prioritization and contact CM Blum or Shea or come to the next Planning Committee meeting if there are any questions or concerns. The Committee would like to finalize the calendar in the next month or so.

XIV. Decision Making Presentation

John Golenski presented Ethical Decision Making theories to the Council. For more information on the presentation, please refer to the audio recording or request a copy of the slides.

XV. AIDS Office Re-bidding Process Update

Russ Zellers (HIV Health Services) handed out an update on the solicitations going out and the solicitations currently under review in the AIDS Office. He mentioned the solicitation plan is currently under revision and additional contracts may be re-bid within the next few months.

CM Shea asked that the Planning Committee be informed whenever a service category is possible going out to bid.

Michelle Long Dixon mentioned the AIDS Office is trying to give the community the ability to give input in the solicitation process.

Public Comment on this item

Bill Hirsh (AIDS Legal Referral Panel) mentioned he was concerned about the tight timelines for response to RFPs.

XVI. December Council Meeting-VOTE

A motion to cancel the December Council Meeting was discussed. The Council voted by hand and the motion did not pass by a 2/3 majority.

The Council discussed rescheduling the December 2003 Council Meeting.

CM Hicks motioned to change the Council Meeting date to December 29, 2003. The motion was seconded. The Council voted on the motion and the motion carried.

XVII. Next Agenda

There were no items mentioned for the next agenda.

XVIII. Adjourned

The meeting was adjourned at 7:30 p.m.

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